MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5083

CERTIFICATE OF DEATH

05073

1

M

I

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel Gen. Nospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 1 RFD 2 30X 877
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Kenneth — Middle: W., JR. — Last: Adams

4. DATE OF DEATH: Month: May — Day: 16 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-3-59
9. AGE (In years last birthday): 1½ yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Kenneth W. Adams, Sr.
14. MOTHER'S MAIDEN NAME: Elizabeth R. Grossman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Father - info. on admission.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Diabetic acidosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO (b): Juvenile diabetes, mellitus. — 1 Day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 15, 1961 to May 16, 1961, that (I) (we) last saw the deceased alive on May 16 1961, and that death occured at 2:57 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Raymond P. Srsic M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 16, 1961
22c. PHYSICIAN'S NAME (Type): RAYMOND P. SRSIC
22d. ADDRESS: SEVERNA PARK, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/19/61
23c. NAME OF CEMETERY OR CREMATORY: Moreland Mem.
23d. LOCATION (City, town or county) (State): Baltimore Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Leonard J. Ruck
ADDRESS: 5305 Harford Rd.

25a. REC'D BY REGISTRAR DATE: MAY 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5084

CERTIFICATE OF DEATH

65074

1

M

I

PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 4months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1668 Bruce Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3V01-4

3. NAME OF DECEASED (Type or print)	First	Middle	Last
	Irvin		Addison

4. DATE OF DEATH: Month 5 — Day 7 — Year 19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Negro		September 9, 1906	54		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown	-------	~~Unknown~~ Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jim Addison	Mary J.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	Unknown	Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cachexia — INTERVAL BETWEEN ONSET AND DEATH

151X

DUE TO (b): Generalized Carcinomatosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Cancer of Stomach

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) ----------

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
------		-------	---------		

21. **I certify** that (I) (this hospital) attended the deceased from 3/29, 1961 to 5/7, 1961., that (I) (we) last saw the deceased alive on 5/7 19 61., and that death occured at 11A.M. from the causes and on the date stated above.

22a. SIGNATURE: Hildegard Heard Reissman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/8/61
22c. PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M.D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
	5-11-61	Mt Olivet	Md

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Leroy B. Nelson 1348 N. Calhoun St

25a. REC'D BY REGISTRAR DATE: MAY 10 '61
25b. REGISTRAR'S SIGNATURE: Clifton L. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5085 — 05075

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2mo. 4 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2207 Druid Hill Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 Vol-4

3. NAME OF DECEASED (Type or print): First: Dora — Middle: — Last: Anderson

4. DATE OF DEATH: Month: 5 — Day: 20 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: December 25, 1897

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Tom Anderson

14. MOTHER'S MAIDEN NAME: Juddey ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-32-0705

17. INFORMANT — Address: Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-respiratory Failure
DUE TO (b): Bronchopneumonia
Conditions, if any, which gave risa to immediate causa (a), stating the underlying causa last. DUE TO (c):
4917

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome Associated with Cardiovascular Disorder

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Hour a.m. p.m. ----- Month, Day, Year 19 ---

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ------

20f. (City or town) (County) (State): ---------

21. I certify that (I) (this hospital) attended the deceased from 3/16 19 61 to 5/20 19 61, that (I) (we) last saw the deceased alive on 5/20 19 61, and that death occured at 4:07A.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/22/61

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 5-25-61

23c. NAME OF CEMETERY OR CREMATORY: Mt Auburn

23d. LOCATION (City, town or county) (State): md

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] — **ADDRESS**: 134 N. Calhoun St

25a. REC'D BY REGISTRAR DATE: MAY 24 '61

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5086 **CERTIFICATE OF DEATH** 05976

Item 6c Film C288 6/19/61 mh

1. PLACE OF DEATH a. COUNTY Anne Arundel — Crownsville State Hospital — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md
c. LENGTH OF STAY IN 1b: 518 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE Maryland — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 141 West St Annapolis Anne Arundel
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First [redacted] Middle Hattie Last BADEN
4. DATE OF DEATH Month May Day 20 Year 1961

5. SEX Male
6. COLOR OR RACE N.
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 11-29-1883
9. AGE (In years last birthday) 77 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Reid
14. MOTHER'S MAIDEN NAME Sedonia Reid Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular death
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: Sudden (5 min)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-19, 1960 to 5-20, 1960, that (I) (we) last saw the deceased alive on 5-20 1960, and that death occured at 12:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE L. Benefiel M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) L. BENEFIEL M.D.
22d. ADDRESS CROWNSVILLE STATE HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 5-24-1961
23c. NAME OF CEMETERY OR CREMATORY Brewerhill
23d. LOCATION (City, town or county) Annapolis (State) Md

24 FUNERAL DIRECTOR'S SIGNATURE Charles Fisher III
ADDRESS Annapolis, Md 45 North West
25a. REC'D BY REGISTRAR DATE MAY 23 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kruse

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. [illegible] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5087

CERTIFICATE OF DEATH

Reg. Dist. No. 1:5077

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARIA Middle Last BALDWIN

4. DATE OF DEATH: Month MAY Day 25 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 24, 1869
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles W. Baldwin
14. MOTHER'S MAIDEN NAME: Annie Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. Fletcher S. Joyce — Address: Millersville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): S.C.V.D. (Sclerotic Cardio Vascular disease)
DUE TO (c): Right Hemiplegia —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1954, to May 25, 1961, that I last saw the deceased alive on 5-25-61 1961, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Felix Fenwick M.D. ADDRESS (Street, city or town, state): P.O. Box 27 DATE SIGNED: 5-26-61

PHYSICIAN'S NAME (Type): Felix Fenwick Odenton Md —

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 28, 1961
22c. NAME OF CEMETERY OR CREMATORY: Baldwin Memorial Cemetery
22d. LOCATION (City, town, or county) (State): Millersville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hopping Funeral Home Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: MAY 29 61
24b. REGISTRAR'S SIGNATURE: Clinton L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be detached for use as the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5088 (035078)

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. STATE: MARYLAND
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Resident or usual residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL - Mayo
d. STREET ADDRESS
e. DID RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: ; Last: BOSTON

4. DATE OF DEATH: Month: May; Day: 21; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 28, 1876

9. AGE (In years last birthday) IF UNDER 1 YEAR: Months; Days; IF UNDER 24 HRS: Hours; Min.: 85 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City or town & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Eugene

14. MOTHER'S MAIDEN NAME: Katie Hunter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SURVIVING SPOUSE OR OTHER INFORMANT: Address: 2183-7115 Georgia Ave. Silver Spring, Md.

17. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 177X
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Carcinoma of the liver of Prostate — 2 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED

20c. TIME OF INJURY: Hour; a.m. p.m.; Month; Day; Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

County

21. I certify that ( ) (I) attended the deceased from April 1, 19 61 to May 20, 1961 that (I) last saw the deceased alive on May 20, 1961 and that death occurred at 12:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: R. L. Richardson

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): R. L. Richardson

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 110 Clay St., Annapolis, Md.

23a. BURIAL CREMATION REMOVAL (Specify)

23b. DATE THEREOF: Burial 5-23-1961

23c. NAME OF CEMETERY OR CREMATORY: Hope Memorial Park

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Williams Funeral Home

25a. RECD BY REGISTRAR DATE: MAY 24 '61

25b. REGISTRAR'S SIGNATURE: Carlton E. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5089

CERTIFICATE OF DEATH

65979

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AI5 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN this place of death: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Lothian
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Emma — Middle: H. — Last: Brady

4. DATE OF DEATH: Month: May — Day: 27 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 31, 1889

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hrs., Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (City or town, State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: JOHN TAYLOR

14. MOTHER'S MAIDEN NAME: SARAH MARSHALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO: no

17. INFORMANT: none — Address: Hospital records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): coronary occlusion
DUE TO (b): coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

WAS OPERATION PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT, HOMICIDE OR SUICIDE? (Specify) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury. Particulars of Part I or Part II of Item 18):

20c. TIME OF INJURY: Hour a.m. p.m. — Month Day Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.):

20f. City or town: — County: — State:

21. **I certify** that (I) (this hospital) attended the deceased from May 19, 1961 to May 27, 1961 that (I) (we) last saw the deceased alive on May 26 1961, and that death occured at 9 AM, from the causes and on the date stated above.

22. SIGNATURE: Emily H. Wilson — M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Dr. Emily Wilson

22d. ADDRESS: Lothian, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 29, 1961

23c. NAME OF CEMETERY OR CREMATORY: St. Luke's Cemetery

23d. LOCATION (City, town, County, State): Lothian, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]

ADDRESS: HOPPING FUNERAL HOME — Annapolis, Maryland

25a. RECD BY REGISTRAR (Date): MAY 31 '61

25b. REGISTRAR'S SIGNATURE: Esther S. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5080 — 65080

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Geo G.Meade
c. LENGTH OF STAY IN 1b: 4 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Army Hospital,Ft Geo G. Meade,Md

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
d. STREET ADDRESS: 301 Queen Ann Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: JOHN — Middle: T. — Last: BRITTAIN
4. DATE OF DEATH: Month: May — Day: 15 — Year: 19 61

5. SEX: MALE
6. COLOR OR RACE: Cau
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 14 January 1921
9. AGE (In years last birthday): 40 yrs
IF UNDER 1 YEAR — Months: — Days: — Hours: — Min:
IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Signal Officer
10b. KIND OF BUSINESS OR INDUSTRY: Army
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Theodore M. Brittain
14. MOTHER'S MAIDEN NAME: Stella Teague

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 311-18-6058
17. INFORMANT: Mrs. Mary E. Brittain, (wife) — Address: 301 Queen Ann Ave, Odenton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Aprox. 20 mi
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6:45pm 15May 19 61 to 7:00pm 15 May 19 61 that (I) (we) last saw the deceased alive on May 15 19 61 and that death occurred at 7PM, from the causes and on the date stated above

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22c. DATE SIGNED: 15 May 1961
22c. PHYSICIAN'S NAME (Type): STANLEY SIEGELMAN,Captain, MC
22d. ADDRESS: U.S.Army Hospital,Ft Geo G. Meade, Md

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 19th May 1960
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
23d. LOCATION (City, town, or county, state): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Glen Burnie, Md.
25a. REC'D BY REGISTRAR — DATE: MAY 19 '61
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached from the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death

VR A1S (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5991 — 65081

TO DE[illegible]MICAL EXAMINER: This certificate should be executed within 24 hours after death. If [illegible]ssary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the [illegible]al director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9,60

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I

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN Md: Term Expires
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
d. STREET ADDRESS: Crownsville State Hospital
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Harry; Middle: ; Last: BRITTON

4. DATE OF DEATH: Month: May; Day: 3; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 1, 1894

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY: Delivery

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Jas. Holliday

14. MOTHER'S MAIDEN NAME: Eliza Britton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-18-4712A

17. INFORMANT: Wm. Britton

Address: 120 E. Chesapeake Ave. Towson, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease.

(b): Exposure.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: ; a.m. p.m. ; Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Wm. V. Lovitt M.D.

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

DATE SIGNED: May 4, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/11/61

22c. NAME OF CEMETERY OR CREMATORY: Stephenson

22d. LOCATION (City, town, or country) (State): Sparks, Balto. Co. Md.

23. FUNERAL DIRECTOR: Wm. L. Whitaman Jr.

ADDRESS: 1701 McCulloh St. Balto. Md.

24a. REC'D BY REGISTRAR DATE: MAY 11 '61

24b. REGISTRAR'S SIGNATURE: Arthur P. Kra[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5092

CERTIFICATE OF DEATH

65082

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN MARYLAND: 2 years 11mos. 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Resident of how long before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give name of town): Forest Hill
d. STREET ADDRESS: Unknown
4. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Janie; Middle: Gordon; Last: Britton

4. DATE OF DEATH: Month: 5; Day: 23; Year: 19 61

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 26, 1874
9. AGE (In years last birthday) IF UNDER 1 YEAR OR UNDER 24 HRS.: 86 yrs. | Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ? Gordon
14. MOTHER'S MAIDEN NAME: Lavinia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: - -
17. INFORMANT: Unknown
Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

WAS AUTOPSY PERFORMED? YES ☐ NO ☒

19. ACCIDENT, INJURY OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part I or Part II of item 18
20c. TIME OF INJURY: Month Day Year Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ While not at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/13, 1958 to 5/23, 1961, that (I) (we) last saw the deceased alive on 5/23, 1961, and that death occured at 2:5 A.M., from the causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 5/23/61
22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/26/61
23c. NAME OF CEMETERY OR CREMATORY: West Liberty
23d. LOCATION (City, town or county): Uppercross Route 7
(State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz
ADDRESS: Jarrettsville, Md
25a. REC'D BY REG'STRAR DATE: MAY 26 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5693 — 05083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b: MARYLAND — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel Gen. Hosp.

2. **USUAL RESIDENCE** (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — d. STREET ADDRESS: Box 269, Rt. 1, Sherwood Forest — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: William — Middle: H — Last: BROWN

4. **DATE OF DEATH**: Month: 5 — Day: 19 — Year: 19 61

5. SEX: Male — 6. COLOR OR RACE: Colored — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 8-17-1902 — 9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months ___ Days ___ — IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): trackman — 10b. KIND OF BUSINESS OR INDUSTRY: railroad — 11. BIRTHPLACE (City & State or foreign country): anne Arundel, Md — 12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Charles Brown — 14. MOTHER'S MAIDEN NAME: MArtha Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no — 16. SOCIAL SECURITY NO.: 218-07-3105 — 17. INFORMANT: Martha Butler Brown — Address: Anne Arundel Co Rt.1 Sherwood Forest

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Post-operative fluid & electrolyte loss — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (b): diffuse abdominal visceral metastasis — 3 wks.

DUE TO (c): Carcinoma, probably primary in pancreas — 12 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Subtal gastrectomy for gastric ulcer, benign, 1955 — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury entered in Part I or Part II of item 18.): -

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 13 ... 19 61 to May 19 , 19 61, that (I) (we) last saw the deceased alive on May 19, 19 61, and that death occurred at 9.25 A.M. P.M. from the causes and on the date stated above.

22a. SIGNATURE: Merton T. Waite, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 5-19-61

22c. PHYSICIAN'S NAME (Type): Merton T. Waite, M.D. — 22d. ADDRESS: 121 Cathedral ST. Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 5-23-61 — 23c. NAME OF CEMETERY OR CREMATORY: Fowlers — 23d. LOCATION (City, town or county): Anne Arundel — (State)

24. FUNERAL DIRECTOR'S SIGNATURE: C. E. Hilo II — ADDRESS: Annapolis, Md

25a. REC'D BY REGISTRAR — DATE: MAY 23 '61 — 25b. REGISTRAR'S SIGNATURE: Clinton S. Hall

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5094 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05084

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: -
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): United States Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence prior to admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits write RURAL): Washington
d. STREET ADDRESS: 1301 Vermont Ave N.W.
ON A FARM? Yes ___ NO [X]

3. NAME OF DECEASED (Type or print): First MARTIN Middle EDWARD Last BYBUTH
4. DATE OF DEATH: Month MAY 25 19 61
5. SEX: Male
6. COLOR OR RACE: Cau
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: February 10, 1896
9. AGE (If under 1 year, at birthday): 65 yrs. IF UNDER 1 YEAR: Months ___ Days ___ Hours ___ Minutes ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer - (Evaluation)
10b. KIND OF BUSINESS OR INDUSTRY: Dept Of Army
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Ole M. Bybuth
14. MOTHER'S MAIDEN NAME: Ingrio Sletmo
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes give war or dates of service): yes WW#1
16. SOCIAL SECURITY NO.: 190-05-3760
17. INFORMANT: Address: Indentification Records Dep of Army

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

AUTOPSY? Yes ___ NO [ ]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II, if applicable.)
20c. TIME OF INJURY: Hour ___ a.m. p.m. Month ___ Day ___ Year 19___
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and that death resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: GUSTAVE H. FALBERT, M.D.
EXAMINER'S NAME (Type): Gustave H. Falbert, M.D.
M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, county):
DATE SIGNED: 25 May 61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/29/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cem.
22d. LOCATION (City, town or country): Arlington, Virginia

23. FUNERAL DIRECTOR: The S. H. Hines Co.
ADDRESS: Washington, D. C.
24a. REC'D BY REGISTRAR DATE: MAY 29 '61
24b. REGISTRAR'S SIGNATURE: S. Hines

TO DEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If ... necessary, please execute the certificate, writing the word "pending" in Pencil in Item 18. Give Pages 1, 2, and 3 to the ... director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5095 — 05985

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 410 State St.
WAS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Sarah; Middle: ; Last: CATTERTON
4. DATE OF DEATH: Month: May; Day: 14; Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: September 4, 1894
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (City & State or Foreign Country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: [illegible]
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give dates of service.):
16. SOCIAL SECURITY NO.:
17. INFORMANT: [illegible] Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE: Uremia
DUE TO: b. Diabetes mellitus
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last: DUE TO: c. nephrosclerosis, hypertensive CVD, coronary artery disease
INTERVAL BETWEEN ONSET AND DEATH: 11 y 9 mos 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.
20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town State

21. I certify that (I) (~~the undersigned~~) attended the deceased from 8-1 ...., 1949 to May 14, 1961 that (I) (~~the~~ last saw the deceased alive on May 13, 1961, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

22. SIGNATURE: Edith Rodler — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Edith Rodler
22d. ADDRESS: 45 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): [illegible]
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: [illegible]
23d. LOCATION (City, town or county, State): Lothian, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: [illegible]
25a. REC'D BY REGISTRAR DATE: MAY 17 '61
25b. REGISTRAR'S SIGNATURE: Gorham L. Hall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5096 — 45086

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Army Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
d. STREET ADDRESS: Rt # 1 Box 307
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First JESSIE — Middle M — Last CHREST
4. DATE OF DEATH: Month MAY — Day 27 — Year 19 61

5 SEX: Female
6 COLOR OR RACE: Cau
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 7 Jan 1887
9 AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (housework)
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: David Reeley
14 MOTHER'S MAIDEN NAME: (unknown) Cheney

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ////////////
16. SOCIAL SECURITY NO: none
17 INFORMANT: (SIL) Charles McAbee — Address: Same as above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Myocardial infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a m / p m — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (~~XXXXXXXX~~) attended the deceased from 8 AM 27 May 19 61 to 8 PM 27 May 19 61 that (I) (we) last saw the deceased alive on 27 May 19 61 and that death occurred at 8:15 PM from the causes and on the date stated above

22a. SIGNATURE: [signature] M D
22b. DATE SIGNED: 27 May 61
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22c PHYSICIAN'S NAME (Type): STANLEY S. SIEGELMAN, Capt., M.C.
22d ADDRESS: USA Hosp Ft Geo G Meade, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 31 st. May 1961
23c NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
23d LOCATION (City, town or county) (State): Woodlawn, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Glen Burnie, Maryland
25a REC'D BY REGISTRAR DATE
25b REGISTRAR'S SIGNATURE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
15M 9 59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5097

65087

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c LENGTH OF STAY IN 1b: 1 year
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 115 wilson road

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland
b COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Glen Burnie
d STREET ADDRESS: 115 wilson Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Estelle — Middle: V. — Last: Coffman

4. DATE OF DEATH: Month: May — Day: — Year: 19 1

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 11th Feb. 1880
9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR, Months: — Days: — IF UNDER 24 HRS. Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser
10b KIND OF BUSINESS OR INDUSTRY: Stadium overwear
11 BIRTHPLACE (State or foreign country): Charlottesville, Va.
12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: Charles W. Rice
14 MOTHER'S MAIDEN NAME: Ida (unknown)

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-14-1441
17. INFORMANT: Mr. Joseph F. Rice — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Hour: a m / p m — Month: — Day: — Year: 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory street, office bldg etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from April 15, 1961, to May 4, 1961 that (I) (we) last saw the deceased alive on 5-1-61 19, and that death occurred at M. from the causes and on the date stated above

22a SIGNATURE: Nathan Racusin — M D — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 5.4.61
22c PHYSICIAN'S NAME (Type): NATHAN RACUSIN
22d ADDRESS: 206 S. Gilmor St. Balto 23, Md

23a BURIAL, CREMATION, REMOVAL (Specify):
23b DATE THEREOF: May 1
23c NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park
23d LOCATION (City, town or county, State): , Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Leonard Kaufman — ADDRESS:
25a REC'D BY REGISTRAR DATE: MAY 3 61
25b REGISTRAR'S SIGNATURE: Esther L. Rice

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9-59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5098 — 65088

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
15M 9/59

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL) and give nearest town: ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 226 GIBSON RD.

2 USUAL RESIDENCE (Where deceased lived. If inst tut on Resident before admiss on)
a. STATE: MARYLAND — b. COUNTY: A.A.Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS — MD.
d. STREET ADDRESS: 40 MUNROE COURT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ROSIE — Middle ESTHER — Last CONDELL

4. DATE OF DEATH: Month 5 — Day 17 — Year 1961

5 SEX: F

6 COLOR OR RACE: W

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 4-6-1896

9 AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b KIND OF BUSINESS OR INDUSTRY: HOME

11 BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN T. CRUTCHLEY

14. MOTHER'S MAIDEN NAME: ALICE A. SEARS

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service):

16 SOCIAL SECURITY NO:

17 INFORMANT: MRS. ROBERT E. McGLENAHAN — Address: #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pneumonia — DUE TO:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Hour, a.m. p.m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 5/14/ 1961, to 5/17/ 1961; that (I) (we) last saw the deceased alive on 5/17/ 1961, and that death occurred at 6:45 A.M. from the causes and on the date stated above

22a SIGNATURE: General Clinic — M.D.

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 5/17/61

22c. PHYSICIAN'S NAME (Type): GERMAN RESEARCH

22d ADDRESS: 121 CAMDEN AVE., ANNAPOLIS

23a BURIAL CREMATION REMOVAL (Specify): BURIAL

23b DATE THEREOF: 5-20-61

23c NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF

23d LOCATION (City, town, or county): ANNAPOLIS — (State): MD.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John M. Boyle & Sons, Annapolis, Md.

25a REC'D BY REGISTRAR DATE: MAY 22 '61

25b REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5099 Reg. Dist. No. 15089

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDGEWATER
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 2 Box 244

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDGEWATER
d. STREET ADDRESS: Route 2 Box 244
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle JOSEPH — Last CULLINANE
4. DATE OF DEATH: Month 5 — Day 31 — Year 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-2-1907
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): INFORMATION SPECIALIST
10b. KIND OF BUSINESS OR INDUSTRY: NATL PARK SERVICE DEP OF INT
11. BIRTHPLACE (State or foreign country): WASHington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: TIMOTHY CULLINANE
14. MOTHER'S MAIDEN NAME: MARY FRAWLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: DOROTHY B. CULLINANE — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gun Shot Wound Abdomen — Instant
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
17 6X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted Gun Shot Wound
20c. TIME OF INJURY: Hour P.M. — Month, Day, Year: 5/31/1961
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Arco — (County): — (State): MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D
NAME (Type): E. Lockhart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/1/61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6-3-61
22c. NAME OF CEMETERY OR CREMATORY: HILLCREST CEM.
22d. LOCATION (City, town, or county): ANNAPOLIS (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John M Taylor & Sons Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: '61
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute Medical Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation.

VS A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5109 — 65090

1 PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 44 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutional resident give place of usual residence)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL): Annapolis
d. STREET ADDRESS: 9 Arbor Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: ROLAND; Last: CURRY

4. DATE OF DEATH: Month: May; Day: 16; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 25, 1916

9. AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sgt Police

10b. KIND OF BUSINESS OR INDUSTRY: Annapolis City

11. BIRTHPLACE (City or Town & State or Foreign Country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William R. Curry

14. MOTHER'S MAIDEN NAME: S. Blanche Howes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): yes World War II

16. SOCIAL SECURITY NO.

17. INFORMANT: Hester M. Curry (2)
Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible]
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part I or Part II or in 18

20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY: Home farm factory street, office bldg. etc.

20f. City or town State

21. I certify that (I) (XXXXXXX personally) attended the deceased from May 16, 1961 to May 16, 1961 that (I) (XXX) last saw the deceased alive on May 16, 1961, and that death occured at 9:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature]

22b. DATE SIGNED: 5/17/61

ATTENDING PHYS XX MED. DIRECTOR ☐ STAFF PHYS ☐ M.D.

22c. PHYSICIAN'S NAME (Type): A. L. Anderson

22d. ADDRESS: 44 Southgate Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 19-1961

23c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff

23d. LOCATION (City, Town or County, State): Annapolis Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John M. Taylor Sons Annapolis Md

25a. REC'D BY REGISTRAR (Date): MAY 22 61

25b. REGISTRAR SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, [illegible]

301 W. Preston St.

CERTIFICATE OF DEATH

Reg Dist. No. 45091

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland — b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Skidmore c. LENGTH OF STAY IN 1b: 10 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Skidmore
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Skidmore	d. STREET ADDRESS: Skidmore e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print)	First: Ollie	Middle	Last: Dean	4 DATE OF DEATH	Month: May	Day: 17	Year: 1961		
5 SEX: Female	6 COLOR OR RACE: Colored	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH: 10-17-1876	9. AGE (In years last birthday): 84 yrs	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS: Hours	Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b KIND OF BUSINESS OR INDUSTRY: **********	11 BIRTHPLACE (State or foreign country): Bolling Green, Va.	12 CITIZEN OF WHAT COUNTRY?: U.S.A.						
13 FATHER'S NAME: Unknown	14 MOTHER'S MAIDEN NAME: Unknown								
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No	16 SOCIAL SECURITY NO: None	INFORMANT: Walter Dean - Wollingford, Pa.	Address: [illegible]						

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Hypertensive cardiovascular disease — 10 years
DUE TO (c):

4 4 3 X

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY	20d INJURY OCCURRED	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
Month, Day, Year; Hour a.m. p.m. 19	While at work ☐ Not while at work ☐				

ATTENDING PHYSICIAN

21. I certify that I attended the deceased from April 15, 1960 to May 17, 1961, that I last saw the deceased alive on May 17, 1961, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore H. Johnson & Sons M.D.
ADDRESS (Street, city or town, state): 37 Calvert Street
DATE SIGNED: May 18, 1961

PHYSICIAN'S NAME (Type): Theodore H. Johnson, M. D. — Annapolis, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town or county)	(State)
Burial	5-20-61	Rollong Green	West Chester	Pa.

23 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a REC'D BY REGISTRAR	24b REGISTRAR'S SIGNATURE
C.E.Hicks III	Annapolis Maryland	DATE MAY 22 '61	[signature]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5102 — 15092

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN this place: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL — Churchton
d. STREET ADDRESS: Franklin Manor
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Lilliam; Middle: ; Last: DePUY

4. DATE OF DEATH: Month: May; Day: 23; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

8. DATE OF BIRTH: Sept. 26, 1908

9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR Months: ; Days: ; IF UNDER 2 HRS. Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hairdresser

10b. KIND OF BUSINESS OR INDUSTRY: Beauty Salon

11. BIRTHPLACE (City or town, State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Victor Launer

14. MOTHER'S MAIDEN NAME: Serena Feher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert Partos — Address: (2)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE: LYMPHOSARCOMA, MALIGNANT, METASTATIC — INTERVAL BETWEEN ONSET AND DEATH: 2 YRS

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20. WAS CASE UNDER MEDICAL EXAMINER OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

21. I certify that (I) (XXXXXXX) attended the deceased from 4-11, 1960 to May 23, 1961, that (I) (XXX) last saw the deceased alive on May 23, 1961, and that death occured at 9:25 A.M. from the causes and on the date stated above

22a. SIGNATURE OF PHYSICIAN (Type): Edward S. Beck — M.D. ATTENDING PHYS. [ ] MED DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5/24/61

22c. PHYSICIAN'S NAME (Type): Edward S. Beck

22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: May 25, 1961

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION (City, town or county): Bladensburg — State: Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John M. Taylor & Sons Annapolis, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 25 '61

25b. REGISTRAR'S SIGNATURE: Anthony L. Krause

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in ... by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers ... and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 ... death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF [illegible]

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65093

1 PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Green Gables, Pasadena
c. LENGTH OF STAY IN MARYLAND: 13 y
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 1, Box 84A

2. USUAL RESIDENCE (Where deceased lived. Do not use business address.)
a. STATE: Md.
b. COUNTY: same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): same
d. STREET ADDRESS: Route 1, Box 84A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Patrick; Middle: Edgar; Last: DeYoung
4. DATE OF DEATH: Month: 5/30/61; Day; Year: 19
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/9/11
9. AGE (In years last birthday) IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min.: 50 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman
10b. KIND OF BUSINESS OR INDUSTRY: same
11. BIRTHPLACE (State or foreign country): Portsmith, Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick DeYoung
14. MOTHER'S MAIDEN NAME: Annie Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Mrs. Vivian Brewer (sister) 3718 Pennington Ave., Curtis Bay, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

4-0-1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL [illegible] AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. DATE OF INJURY Month Day Year Hour a.m. p.m. 19 While at work ☐ Not While at work ☐
20d. PLACE OF INJURY (e.g., factory, street, office bldg., etc.)
20e. [illegible]

21. I certify that I took charge of the [illegible] described above, held a[illegible] ☐ [illegible] on ☒ [illegible] ☒ death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type or print): Gustave H. Faubert
DATE SIGNED: 5/30/61
Address (Street, city or town): Glen Burnie, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: 6/3/61
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem
22d. LOCATION (City or town): Glen Burnie, Md.
ADDRESS:

23. FUNERAL DIRECTOR: McCully Funeral Homes 130 E. Fort Ave. # 30

24a. REC'D BY REG STRAR DATE: JUN 2 '61
24b. REGISTRAR [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate pending the report of the autopsy in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: 3 should be given to the person acting as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5104

CERTIFICATE OF DEATH

65094

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN this place: 3 years 9mos. 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits write RURAL): Baltimore
d. STREET ADDRESS: 2325 Braddish Avenue
e. RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Raymond; Middle: Bishop; Last: Evans

4. DATE OF DEATH: Month: 5; Day: 31; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: April 5, 1892

9. AGE In years last birthday: 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (City & State or Foreign Country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Evans

14. MOTHER'S MAIDEN NAME: Anna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-14-4081

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b): ------
DUE TO (c): ------

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Pick's Disease

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18): ------

20c. TIME OF INJURY: Hour a.m. p.m. ------ Month Day Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ------

20f. City or town: ------ County: ------ State:

21. I certify that (I) (this hospital) attended the deceased from 8/6. ....., 1957 to 5/31..... , 1961 that (I) (we) last saw the deceased alive on 5/31 , 1961, and that death occured at 1P.M. from the causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D.

22b. DATE SIGNED: 5/31/61

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

M.D. ATTENDING PHYS [ ] MED. DIRECTOR [X] STAFF PHYS. [ ]

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL CREMATION REMOVAL (Specify)

23b. DATE THEREOF: 6-3-61

23c. NAME OF CEMETERY OR CREMATORY: Arlington

23d. LOCATION City town or county (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Wm. J. Ritter 1348 N. Calhoun St

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE: JUN 2 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5165

CERTIFICATE OF DEATH

Reg. Dist. No. 05095

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rt 1 Box 165

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Baltimore~~ Glen Burnie
e. STREET ADDRESS: Rt 1 Box 165
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rosalia — Middle: — Last: Fischer

4. DATE OF DEATH: Month: 5 — Day: 1 — Year: 19 61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 12, 1879

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hungary

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Kanengershur

14. MOTHER'S MAIDEN NAME: Margaret Bicking

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 1 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible] 19[illegible], to [illegible] 19[illegible], that I last saw the deceased alive on [illegible] 19[illegible], and that death occurred at [illegible] M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. — ADDRESS (Street, city or town, state): [illegible] — DATE SIGNED

PHYSICIAN'S NAME (Type): [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b. DATE THEREOF: 5/4/61

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park

22d. LOCATION (City, town or county) (State): Baltimore 29, Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCully Funeral Homes 130 E. Fort Ave.

24a. REC'D BY REGISTRAR — DATE: MAY 3 '61

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9-55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5106 — 05096

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If inst'l Res. refer to address)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Harwood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Fannie — Middle: — Last: FISHER

4. DATE OF DEATH: Month: May — Day: 3 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: February 26, 1873

9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR Months | Days | IF UNDER 2 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George W. Owens

14. MOTHER'S MAIDEN NAME: ELLEN ATWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: ELIZABETH SHEPHERD HAYWARD (wife)
Address:

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): (patient taken bleeding)
DUE TO: b: hypostatic pneumonia
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO: (c): Herpes Zoster

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town — County — State

21. **I certify** that (I) (~~attended~~) attended the deceased from April 16, 1961 to May 3, 1961 that (I) (~~saw~~) last saw the deceased alive on May 3, 1961, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Emily H. Wilson M.D.

ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Emily H. Wilson, M.D.

22d. ADDRESS: Lothian, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 6 1961

23c. NAME OF CEMETERY OR CREMATORY: Mt Zion

23d. LOCATION (City, town or county, State): Lothian, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty

ADDRESS: Lothian Md

25a. REC'D BY REGISTRAR: MAY 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur P. Howe

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5107 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** C5097

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PHS. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
   c. LENGTH OF STAY IN: MARYLAND 4 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 102 Whip Lane, Country Club Estate.

2. USUAL RESIDENCE (Where deceased lived if not in hospital)
   a. STATE: Same
   b. COUNTY: Same
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
   d. STREET ADDRESS: Same
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First G. Last — George Edward Fortmiller

4. DATE OF DEATH: May 8th. 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/6/11

9. AGE (If less than 1 day, number of MINUTES. If less than 1 year, number of DAYS. If less than 1 day, number of HOURS. If less than 1 year, number of MONTHS. If less than 1 month, number of DAYS. If 100 years or more, number of CENTURIES.) (Last birthday) Years: 49 | Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Fortmiller

14. MOTHER'S MAIDEN NAME: Agnes Diepold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Burnadette Fortmiller (wife) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Self inflicted wound to his brain with a 10 gauge — INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) pump shot gun .

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. WAS EXTERNAL CAUSE PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) As per #18

20c. TIME OF INJURY: Month, Day, Year: 9.30 a.m. p.m. 5/8/61 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. City or town: Glen Burnie — State: A.A. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D.

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 5/8/61

Address (Street, city, town, or county): Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 5/9/61

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR: Hopkins and Kirkley

ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: MAY 12 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5108 — 65098

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN this place
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nutwell
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Notca — Middle: Tremal — Last: Garrett

4. DATE OF DEATH: Month: May — Day: 12, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 17, 1960

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 9 Days: 25 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City & State or Foreign Country): Anne Arundel County Md.

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Charles R. Garrett

14. MOTHER'S MAIDEN NAME: Florine L. Wills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records — Address: Hortes Garrett N. Capitol Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO (b): Anemia, Megaloblastic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month — Day — Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town — County — State

21. I certify that I, (this hospital) attended the deceased from ..., 19, to ..., 19..., that (I) (we) last saw the deceased alive on ..., 19, and that death occured at ... M, from the causes and on the date stated above

22a. SIGNATURE: Clayton Norton M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/16/61

22c. PHYSICIAN'S NAME (Type): Dr. Clayton Norton

22d. ADDRESS: Medical Building Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial 5-16-1961

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Mozes

23d. LOCATION (City, town or county): Severna Park Md.

24. FUNERAL DIRECTOR'S SIGNATURE: William Beadle

ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: MAY 17 '61

25b. REGISTRAR'S SIGNATURE: Clayton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5109 — 15099

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day +
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give name of nearest town): RURAL – Annapolis
d. STREET ADDRESS: Rt-2, Box-97
IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY BOY; Middle: ; Last: GILLIS
4. DATE OF DEATH: Month: May; Day: 2; Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 30, 1960
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 1; Days: 9; IF UNDER 24 HRS: Hours: ; Min.: 35
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): baby
10b. KIND OF BUSINESS OR INDUSTRY: Maryland
11. BIRTHPLACE (City & State or Foreign Country): U.S.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Gilbert John GILLIS, Jr.
14. MOTHER'S MAIDEN NAME: Dolores Josephine SUMMERS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE: Multiple congenital malformations incompatible with life.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of 18)
20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town County

21. I certify that (I (~~XXXXXXX~~) attended the deceased from April 30, , 1961 to May 1, , 1961, that (I) (~~XX~~) last saw the deceased alive on May 1, 1961, and that death occured at 2:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Albert R. Anderson
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/2/61
22c. PHYSICIAN'S NAME (Type): A. L. Anderson
22d. ADDRESS: 44 SouthgateAve., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/3/61
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City, town, county, State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Howard H. Hubbard 4107 Wilkens Ave.
25a. REC'D BY REGISTRAR DATE: MAY 4 '61
25b. REGISTRAR'S SIGNATURE: Clarence L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5119 — 05100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** Where deceased lived, (If institution Resident Patient Transient)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL - Annapolis
   d. STREET ADDRESS: Defense Highway — e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Stephen — Middle: P — Last: GOMOLJAK

4. **DATE OF DEATH**: Month: May — Day: 9 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Aug. 7, 1897

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret, U.S Gov.

10b. KIND OF BUSINESS OR INDUSTRY: Carpenter

11. BIRTHPLACE (City & State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Gomoljak

14. MOTHER'S MAIDEN NAME: Mary (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: none — Address: Mrs. Teresa M. Gomoljak, Wife- Same as # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): DISSECTING ANEURYSM, ABD. AORTA — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.: HYPERTENSIVE CARDIOVASCULAR DISEASE

19. WAS A TOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of Item 18:

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day Year 19 — 20d. INJURY OCCURRED While at work [ ] Not While at work [ ] — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. City or town — County — State

21. **I certify** that (I) (XXXXXXXXX) attended the deceased from 7 MAY, 19 61 to May 9, 19 61 that (I) (XXe) last saw the deceased alive on May 9, 19 61, and that death occurred at 8:55 A.M., from the causes and on the date stated above

22a. SIGNATURE: Edward S Beck — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 5/9/61

22c. PHYSICIAN'S NAME (Type): Edward S. Beck

22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: May 13,61 — 23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery — 23d. LOCATION (City, town or county): Annapolis, Md. — State

24. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: MAY 11 '61 — 25b. REGISTRAR'S SIGNATURE: Clifton S Frame

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5111 — 05101

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN MD: 18 years 10mos. 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
STREET ADDRESS: 773 Vine Street
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: — Last: Green

4. DATE OF DEATH: Month: 5 — Day: 24 — Year: 19 61

5. SEX: Female — 6. COLOR OR RACE: Negro — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 1882 — 9. AGE (In years last birthday): 78 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework — 10b. KIND OF BUSINESS OR INDUSTRY: ------- — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Green — 14. MOTHER'S MAIDEN NAME: Harriet Haynes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No — SOCIAL SECURITY NO.: Unknown — 17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cachexia & Septicemia — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Bed Sores
DUE TO (c): 715X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Chronic Brain Syndrome Associated with Senile Psychosis — WAS AUTOPSY PERFORMED? YES ☐ NO ☒

19. WAS AUTOPSY PERFORMED?

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part II or Part I of item 18): -------
20c. TIME OF INJURY: Hour a.m. p.m. ----- Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): --------
20f. City or town / County / State: --------

21. I certify that (I) (this hospital) attended the deceased from 5/11 .., 1942, to 5/24 ., 19 61, that (I) (we) last saw the deceased alive on 5/24 .. 19 61, and that death occured at 1:40 M, from the causes and on the date stated above

22a. SIGNATURE: Hildegard Heard Reissman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/24/61
22c. PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: [illegible]
23c. NAME OF CEMETERY OR CREMATORY: [illegible]
23d. LOCATION (City, town or county) (State): [illegible]

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: [illegible]

25a. REC'D BY REGISTRAR DATE: MAY 31 '61
25b. REGISTRAR'S SIGNATURE: Charles L. Hinds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Item 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Fi m 3.68 6/61 iwk

CERTIFICATE OF DEATH

5112

Reg. Dist. No. 05102

1 PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Churchton
d. STREET ADDRESS: Shady Side Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Eugene Middle: [illegible] Last: Gross
4 DATE OF DEATH: Month: May Day: 21 Year: 1961

5 SEX: Female
6 COLOR OR RACE: Negro
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Feb. 18, 1883
9. AGE (Last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Churchton Md
12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: John Nick
14 MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):
16 SOCIAL SECURITY NO.: ?
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a m p m Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from May 11 1961 to May 21 1961, that I last saw the deceased alive on May 21 1961, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Fiskard Smith M.D. ADDRESS (Street, city or town, state): Shady Side, Md. DATE SIGNED: 5/22/61
PHYSICIAN'S NAME (Type): FISKARD F. SMITH

22a BURIAL, CREMATION, REMOVAL (Specify)
22b DATE THEREOF: May 24 1961
22c NAME OF CEMETERY OR CREMATORY: Forest Cemetery
22d LOCATION (City, town, or county) (State):

23 FUNERAL DIRECTOR'S SIGNATURE: Bernard Harden ADDRESS: Galesville, Md.
24a REC'D BY REGISTRAR DATE: MAY 29 '61
24b REGISTRAR'S SIGNATURE: Ostling S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5113 — 05103

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission.)
a. STATE: Mayyland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL): RURAL — Edgewater
d. STREET ADDRESS: Rt-2, Box-130
IF RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Matilda; Middle: ; Last: GROSS

4. DATE OF DEATH: Month: May; Day: 22; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Jan. 31, 1895

9. AGE (In years last birthday. If under 1 year, months, days, hours): 66 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. CITIZEN OF WHAT COUNTRY? U.S.

12. [illegible] Maryland

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unkown) If yes give war or dates of service:

16. SOCIAL SECURITY NO:

17. INFORMANT: [illegible] Address: [illegible]

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction of Left Ventricle
DUE TO (b): Coronary artery sclerosis with atheromatous occlusion, Right Coronary Artery
DUE TO (c): [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS contributing to death but not related to terminal disease condition given in Part I.: Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19. WAS OPERATION PERFORMED? YES XX NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER

20b. DESCRIBE HOW INJURY OCCURRED (Give nature of injury in Part I or Part II.):

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: Where: at work [ ] Not Where: at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg.):

20f. City or town:

21. I certify that I (XXXXXXXX) attended the deceased from May 13, 1961 to May 22, 1961. I (XXX) last saw the deceased alive on May 22, 1961 and that death occured at 1:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. L. Richardson

22b. DATE SIGNED: 5/23/61

ATTENDING PHYS XX MED DIRECTOR [ ] STAFF PHYS [ ] M.D.

22c. PHYSICIAN'S NAME (Type): R. L. Richardson

22d. ADDRESS: 110 Clay St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-27-1961

23c. NAME OF CEMETERY OR CREMATORY: Bennett Hill

23d. LOCATION (City, town or county): Annapolis, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]

ADDRESS: [illegible]

25a. RECD BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE MAY 24 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5114 — 05104

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9'60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, D.C.
d. STREET ADDRESS: 1114 OL. RD., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: HAMM
4. DATE OF DEATH: Month: May — Day: 24, — Year: 1961

5. SEX: Male
6. COLOR OR RACE: COL.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5.2[illegible].04
9. AGE (In years last birthday): [illegible] yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. GOV'T.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOV'T
11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES HAMM
14. MOTHER'S MAIDEN NAME: ELIZABETH ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. GERTRUDE H. HAMM — Address: WASHINGTON, D.C. [illegible] RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease. — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D. — M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city town or county):
DATE SIGNED: May 25, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5.27.61
22c. NAME OF CEMETERY OR CREMATORY: LINCOLN MEM. CEM.
22d. LOCATION (City, town, or country) (State): SUITLAND, MARYLAND

23. FUNERAL DIRECTOR: ROBERT J. McGUIRE Jr. — ADDRESS: 10 9TH ST., N.W. WASHINGTON, D.C.
24a. REC'D BY REGISTRAR DATE: MAY 2[illegible]
24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5115

CERTIFICATE OF DEATH

Reg. Dist No. 05105

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c LENGTH OF STAY IN 1b: Life
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route 2 - Box 430

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland
b COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
d STREET ADDRESS: Route 2 Box 430
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Timothy (Tim) Middle: Julius Last: Harris

4 DATE OF DEATH: Month: May Day: 6 Year: 1961

5 SEX: Male

6 COLOR OR RACE: Colored

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Jan. 14-1891

9 AGE (In years last birthday) 70 yrs — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmers - Helper

10b KIND OF BUSINESS OR INDUSTRY: **********

11 BIRTHPLACE (State or foreign country): A.A.Co. Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julius Harris

14. MOTHER'S MAIDEN NAME: Louise Colbert

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16 SOCIAL SECURITY NO: 214-18-7669

INFORMANT: Ida R. Harris-Rt. 2-Box 430 Annapolis, Md. (Address)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma / Pancreas
DUE TO (b): with metastasis
DUE TO (c): to liver

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-21-61, 19 to 5-6-61, 19, that I last saw the deceased alive on 5-4-61, 19, and that death occurred at 7:__ M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE: A.T. Allen MD

PHYSICIAN'S NAME (Type) A.T.Allen — Cathedral Street- Annaplois, Md.

22a BURIAL, CREMATION REMOVAL (Specify): Burial

22b DATE THEREOF: 5-9-61

22c NAME OF CEMETERY OR CREMATORY: Broadneck

22d LOCATION (City, town, or county) (State): Rt. 2 A.A.Co. Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: C.E.Hicks III

ADDRESS: Annapolis, Maryland

24a. RECD BY REGISTRAR DATE MAY 9 '61

24b REGISTRAR'S SIGNATURE: Clifton E. Hicks

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be delivered by the hospital or attending physician. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5116 — 05106

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN: MARYLAND 43 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 407 Severn Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution, give last usual residence)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL): 18 Annapolis
STREET ADDRESS: 407 Severn Avenue
RESIDENCE ON A FARM? NO [X]

3. NAME OF DECEASED (Type or print): First: Frances; Middle: Isabelle; Last: Hartge

4. DATE OF DEATH: Month: 5; Day: 29; Year: 1961

5. SEX: F

6. COLOR: W

7. MARRIED [X] NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH: 8/20/86

9. AGE (If less than last birthday) Years: 74 Months Days Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE: U.S.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: W.T. Rogers

14. MOTHER'S MAIDEN NAME: Alverta Atwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) If yes, give war or date of service: No

16. SOCIAL SECURITY NO.

17. INFORMANT: Louis Hartge — Address: 407 Severn Ave, Annapolis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized metastases — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO
(b): Undifferentiated transitional cell carcinoma of bladder — 1 year
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.: None

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part I or Part II of Item 18

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

21. I certify that (I) ~~(this hospital)~~ attended the deceased from March 1, 1961, to May 29, 1961, that (I) ~~(we)~~ last saw the deceased alive on 5/29, 1961, and that death occured at 10:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman

M.D. — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED: 5/29/61

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman, M.D.

22d. ADDRESS: 100 Cathedral Street, Annapolis, Md.

23a. BURIAL ~~CREMATION~~ REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-31-61

23c. NAME OF CEMETERY OR CREMATORY: CEDAR Bluff

23d. LOCATION City, town or county: ANNAPOLIS — State: MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John W. Ky Ford & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REG STRAR — DATE: JUN 2 '61

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5117 — 65107

1. PLACE OF DEATH
a. COUNTY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits write RURAL and give
STREET ADDRESS
RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED (Type or print) — First: DAVID — Middle: E — Last: HENRY

4. DATE OF DEATH — Month, Day, Year: 19

5. SEX — 6. COLOR OR RACE — 7. MARRIED | NEVER MARRIED | WIDOWED | DIVORCED — DATE OF BIRTH — 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours

10a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) — None
10b. KIND OF BUSINESS OR INDUSTRY — None
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) — MD

13. FATHER'S NAME — ENOCH HENRY
14. MOTHER'S MAIDEN NAME — MARY FRAMPTON
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address — LEMAR HENRY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) — Dehydration & malnutrition — INTERVAL BETWEEN ONSET AND DEATH — 3-4 days
DUE TO (b) — Old age
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) — Hardening of the arteries
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT WAS UNDER YING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-4 19 60 to 5-27 19 61, that (I) (we) last saw the deceased alive on 5-27 19 61, and that death occured at 4:20 PM, from the causes and on the date stated above.

22a. SIGNATURE — Barbara Henry — M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED — 5-31-61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF
23. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS
25a. REC'D BY REGISTRAR DATE JUN 1 '61
25b. REGISTRAR'S SIGNATURE — Arthur S Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5113 — 05108

1 PLACE OF DEATH
a. COUNTY: Anne-Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1da
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Anne-Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 930 W. Pratt St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith — Middle: M. — Last: Hirschmann
4. DATE OF DEATH: Month: 5 — Day: 10 — Year: 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/12/1893
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR OLD OR UNDER 24 HRS: Months | Days | Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George Russell
14. MOTHER'S MAIDEN NAME: Anna Franklin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Charles R. Hirschmann Jr. — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Hypertensive Cardio-Vas Disease — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 10 19 61 to — 19 61 that (I) (we) last saw the deceased alive on May 11 19 61 and that death occurred at 5 P M, from the causes and on the date stated above

22a. SIGNATURE: Charles Tommasello — M D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 5/11/61
22c. PHYSICIAN'S NAME (Type): Charles Tommasello
22d. ADDRESS: 910 W. Lombard St. Baltimore

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/13/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
23d. LOCATION (City, town, or county; State): Ritchie Highway Anl.

24. FUNERAL DIRECTOR'S SIGNATURE: John J. Countermine — ADDRESS: 9 Holliday St.
25a. REC'D BY REGISTRAR DATE: MAY 12 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5113 Reg. Dist. No. 05109

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Rt. 1- Box 195

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and g ve nearest town): Severn
d. STREET ADDRESS: Rt. 1- Box 195
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Walter — Middle: J. — Last: Holm

4. DATE OF DEATH: Month: May — Day: 20 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARR ED ☐ W DOWED ☐ DIVORCED ☐

8. DATE OF B.RTH: 12 Feb, 1878

9. AGE (In years last b rthday): 83 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 4 HRS.: Hours / Min

10a. USUAL OCCUPAT ON (Give kind of work done dur ng most of working life even if retired): Heating Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Civil Service

11. BIRTHPLACE (State or foreign country): New Orleans, La

12. C TIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Julius Holm

14. MOTHER'S MAIDEN NAME: (Unknown) Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Mamie I. Holm — Address: Same as No. 2

MEDICAL CERTIFICAT ON

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH:

427.1

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

DUE TO (b): Auricular Fibrillation

DUE TO (c): Arteriosclerotic Heart Disease

PART II OTHER SIGNIFICANT COND TIONS CONTRIBUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from April 15, 1961, to May 20, 1961, that I last saw the deceased alive on 5-17, 1961, and that death occurred at 11:22 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D. — ADDRESS (Street, city or town, state): [illegible] — DATE SIGNED: 5-20-61

PHYSICIAN'S NAME (Type): [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 24-May 1961

22c. NAME OF CEMETERY OR CREMATORY: Balto. Nat'l. Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore - Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Singleton Funeral Home - Robert P. Ware — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR — DATE: MAY 23 61

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5120 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05110

TO DE[illegible] MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an [illegible]ssary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the [illegible]al director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~West Minister~~ Westminster
   d. STREET ADDRESS: 54 Liberty Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): ~~CHARLES~~ CARVEL HORTON
4. DATE OF DEATH: Month: May — Day: 21, — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-21-1897
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver
10b. KIND OF BUSINESS OR INDUSTRY: S.H. C.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Howard M. Horton
14. MOTHER'S MAIDEN NAME: Margaret Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes
16. SOCIAL SECURITY NO. (If yes give war or dates of service): W.W. 1 218-05-1403
17. INFORMANT: Mrs. Zelda L. Horton, same — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): 9 7 1.8

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year: 5/21/1961
20d. INJURY OCCURRED — While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☐. Accident ☒ Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: Russell S Fisher M D
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):
DATE SIGNED: 5/22/61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5-24-1961
22c. NAME OF CEMETERY OR CREMATORY: Evergreen Mem. Gardens
22d. LOCATION (City, town, or country): Finksburg, Md. (State)

23. FUNERAL DIRECTOR — ADDRESS: C. M. Waltz, Winfield, Maryland
24a. REC'D BY REGISTRAR — DATE: MAY 24 '61
24b. REGISTRAR'S SIGNATURE:

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5121 — 05111

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1½ days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Harwood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Bertram — Middle: Leon — Last: IRELAND

4. DATE OF DEATH: Month: May — Day: 9 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 8, 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR Months: 1 Days — IF UNDER 24 HRS Hours: 11 Min.: 53

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank M. IRELAND

14. MOTHER'S MAIDEN NAME: Elsie Louise PADDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records.

Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year, 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town — County — State(s)

21. I certify that (I) (~~xxxxxxx~~) attended the deceased from May 8, 1961 to May 9, 1961, that (I) (~~xxx~~) last saw the deceased alive on May 9, 1961, and that death occured at 2:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Stuart H. Walker MD

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 5-11-61

22c. PHYSICIAN'S NAME (Type): Stuart H. Walker

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-11-61

23c. NAME OF CEMETERY OR CREMATORY: Mt Zion

23d. LOCATION (City, town or county, State): Lothian Md

24. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty

ADDRESS: Galesville Md

25a. REC'D BY REGISTRAR DATE: MAY 17 '61

25b. REGISTRAR'S SIGNATURE: Lindsay L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. ... be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

TO DE. .Y MEDICAL EXAMINER: This certificate should be executed within 24 hours after ...th. If a ...play is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages ... 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. P...

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fi... ...rector. Page ...files

FOR ... HEALT...

VS. A15ML
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05112

STATE DEPT. M I

1 PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 25
c. LENGTH OF STAY IN 1b: Few instants
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Johnson used cars lot, Belle Grove Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission.)
a. STATE: Maryland
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 25
d. STREET ADDRESS: 25 Nann Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: George — Middle: Leroy — Last: Isaacs Jr.

4 DATE OF DEATH: May the tenth 19 61

5 SEX: M

6 COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/8/24

9 AGE (Last birthday): 36 yrs — If UNDER 1 YEAR: Months | Days | Hours | Min

10a. OCCUPATION (Kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Anchor Meter Prt.

11. BIRTHPLACE (State or foreign country): Brooklyn, N.Y.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Leroy Isaacs

14. MOTHER'S MAIDEN NAME: Jessie A. Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 144-18-1489

17 INFORMANT: Mrs. Mary Isaacs, (wife)

Address: Same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Strangulation, by hanging himself with a rope.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS. CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS (Probably ☒, Contributing ☐) CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18): (screwed to apoll) Tied one end of arope around his neck and the other end to ahook

20c. TIME OF INJURY: 7.30 (Hour a.m./p.m.) 5/10/61 (Month, Day, Year)

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Bellegrove Rd.

20f. (City or town): Baltimore 25, A.A.

State: Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, County ☒ and that death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF M.D.: [signature]

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 5/10/61

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

Address (Street, city, town or county): Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 15, 1961

22c. NAME OF CEMETERY OR CREMATORY: Shore Land Mem. Gardens

22d. LOCATION (City, town, state): Keyport, New Jersey

23 FUNERAL DIRECTOR: [signature]

ADDRESS: 4001 Ritchie Hwy. Balto 25, Md.

24a. RECD BY REGISTRAR (Date): MAY 16 '61

24b. REGISTRAR'S SIGNATURE: [signature]

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5123

CERTIFICATE OF DEATH

Reg. Dist. No. 05113

1. PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS Murray St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Lizzie Middle: [illegible] Last: Hicks

4. DATE OF DEATH Month: May Day: [illegible] Year: 19 61

5. SEX: Fem.
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar. 2 1876
9. AGE (In years last birthday) 85 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done dur ng most of working life, even if retired) Laundress
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or for gn country) U. S. A.
12. CIT ZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME John H. Baskett
14. MOTHER'S MAIDEN NAME Margaret Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Helen McCarty Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis & arterial
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Arteriosclerosis, C. V. D.
DUE TO
(c) Gen. arterio sclerosis
INTERVAL BETWEEN ONSET AND DEATH: 5 y

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1957 to May 29, 1961, that I last saw the deceased alive on 5-24-61, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Edith Radke M.D.
ADDRESS (Street, city or town, state) 45 Franklin St., Annapolis
DATE SIGNED 6-1-61
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF June 2/61
22c. NAME OF CEMETERY OR CREMATORY St. Mary's
22d. LOCATION (City, town, or county) Home for the (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE J. B. Pittman
ADDRESS Annapolis
24a. REC'D BY REGISTRAR DATE JUN 5 '61
24b. REGISTRAR'S SIGNATURE Arthur L. Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5124 — 05114

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Geo G. Meade
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: United States Army Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 709 Park Ave Apt # 15
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: KAREN — Middle: MARIE — Last: JAHNCKE

4. DATE OF DEATH: Month: MAY — Day: 6 — Year: 19 61

5 SEX: Female

6 COLOR OR RACE: Cau

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ N/A DIVORCED ☐

8. DATE OF BIRTH: 4 May 61

9 AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months — Days: 2 — IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): –

10b KIND OF BUSINESS OR INDUSTRY: –

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JAMES H. JAHNCKE

14. MOTHER'S MAIDEN NAME: MARLENE BURKEY

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): – (If yes, give war or dates of service): –

16. SOCIAL SECURITY NO: –

17. INFORMANT: Father — Address: 709 Park Ave Laurel, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (~~XXXXXXXX~~) attended the deceased from 4 May 19 61 to 19 that (I) (we) last saw the deceased alive on 6 May 1961, and that death occurred at 9:37 A.M. from the causes and on the date stated above

22a SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 6 May 61

22c PHYSICIAN'S NAME (Type): SHERMAN S. ROBINSON, Capt., M.C.
22d ADDRESS: USA Hosp Ft Geo G. Meade, Md.

23a BURIAL, CREMATION, REMOVAL (Specify) 23b DATE THEREOF: 9/7/61
23c NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d LOCATION (City, town, or county, State)

24. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS
25a. REC'D BY REGISTRAR DATE
25b REGISTRAR'S SIGNATURE

THE HEALTH OFFICER, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4, 15M 9.59)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5125

CERTIFICATE OF DEATH

Reg. Dist. No. 05115

1. PLACE OF DEATH
a. COUNTY [illegible] MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible] Highs.

c. LENGTH OF STAY IN 1b: 2 1/2 yrs.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE [illegible] b. COUNTY [illegible]

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Hgts.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible] Road

d. STREET ADDRESS #479 Virginia Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTHA Middle SUSAN Last JENKINS

4. DATE OF DEATH: Month MAY Day 29th Year 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 18th May 1880

9. AGE (In years last birthday) 81 yrs

IF UNDER 1 YEAR: Months Days Hours Min

IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible] (Craft.)

10b. KIND OF BUSINESS OR INDUSTRY [illegible]

11. BIRTHPLACE (State or foreign country) Virginia ([illegible])

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph W. Howell

14. MOTHER'S MAIDEN NAME: Rosalie Jacobs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) 7777 7777

16. SOCIAL SECURITY NO [illegible]

17. INFORMANT: Mrs. Nesbit L. Jenkins Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART Failure

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible] 19____, to [illegible] 19____, that I last saw the deceased alive on [illegible] 19____, and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE [illegible] M.D.

ADDRESS (Street, city or town, state) [illegible] DATE SIGNED [illegible]

PHYSICIAN'S NAME (Type) [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 31st May 1961

22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery

22d. LOCATION (City, town, or county) (State) Baltimore, [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE [illegible]

ADDRESS Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE JUN 1 '61

24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the [illegible] burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit, page 3 should be detached for use as the [illegible] and the remainder should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5126 — 05116

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: MD. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
d. STREET ADDRESS: Box 400.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: James — Middle: F. — Last: Jennings

4. DATE OF DEATH: Month: 5 — Day: 24-61 — Year: 19

5. SEX: M.
6. COLOR OR RACE: C
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 4-4-23
9. AGE (In years last birthday): 38 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer, Farmer (Farm)
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (City & State or Foreign country): Anne Arundel County
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Franklin Jennings
14. MOTHER'S MAIDEN NAME: Lucy Belle Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes, 2nd World War
16. SOCIAL SECURITY NO.
17. INFORMANT: [illegible] — Address: [illegible]

18. CAUSE OF DEATH [Enter only one cause per line for a, b, and c.]

PART I. DEATH WAS CAUSED BY
a. IMMEDIATE CAUSE: Uremia — Myocarditis, Interstitial — Hypertension
DUE TO
b. Chronic Glomerulo Nephritis
DUE TO
c. Pulmonary Hypertension

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): 1957
20f. City or town — County — State

21 I certify that ( ) ~~(this hospital)~~ attended the deceased from 5-9-61 19, to 5-24-61, 19, that (I) (~~not~~) last saw the deceased alive on 5-23-61 19, and that death occured at .... M, from the causes and on the date stated above.

22a. SIGNATURE: Robert P. Holland, M.D.
22b. DATE SIGNED: 5-26-61
ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]
22c. PHYSICIAN'S NAME (Type): Robert P. Holland
22d. ADDRESS: [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 5-27-61
23c. NAME OF CEMETERY OR CREMATORY: Pinelick Cem.
23d. LOCATION (City, town or county) (State): [illegible]

24 FUNERAL DIRECTOR'S SIGNATURE: Arnold A. Shriver
ADDRESS: Annapolis

25a. REC'D BY REGISTRAR DATE: MAY 26 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5127 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05117

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 621 Second St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BELINDA Middle Last JOHNSON
4. DATE OF DEATH: Month May Day 14, Year 1961
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 4, 1961
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months 4 Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alexander Johnson III
14. MOTHER'S MAIDEN NAME: Linda Coffee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Alexander Johnson III 621 2nd St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial Pneumonitis
525X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. S. Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
Address (Street, city, town, or county):
DATE SIGNED: 5/15/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-16-1961
22c. NAME OF CEMETERY OR CREMATORY: Forest Lawn
22d. LOCATION (City, town, or country) (State): Bestgate Ext.

23. FUNERAL DIRECTOR: Watkins & Rees #1 Annapolis Md.
ADDRESS:
24a. RECD BY REGISTRAR DATE: MAY 17 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kunz

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy, inquest, or other necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

1

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5128

CERTIFICATE OF DEATH

Reg. Dist. No. 05118

1 PLACE OF DEATH
a COUNTY Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a STATE D.C — b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.

c LENGTH OF STAY N 1b 3 yrs.

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.

d NAME OF HOSPITAL OR INSTITUTION District Training School Children's Center

d STREET ADDRESS 300 - 16th Street N.E.

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Donald Middle Lee Last Johnson

4 DATE OF DEATH Month May Day 19 Year 1961

5. SEX male

6 COLOR OR RACE White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH June 17, 1956

9 AGE (In years last birthday) 4 yrs

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized

10b KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Washington, D.C.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Leonard Leroy Johnson

14. MOTHER'S MAIDEN NAME Shirley Stuckey

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —

(If yes, give war or dates of service)

16 SOCIAL SECURITY NO —

INFORMANT Address Children's Center, Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Microcephaly

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Mental Retardation

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 14, 1958, to May 19, , 1961, that I last saw the deceased alive on May 19, , 1961, and that death occurred at 6:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Margaret W. Mola M.D. ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED 5/19/61

PHYSICIAN'S NAME (Type) Margaret W. Mola, M.D. Children's Center, Laurel, Md. 5/19/61

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF May 23, 1961

22c. NAME OF CEMETERY OR CREMATORY District Training School

22d LOCATION (City, town, or county) Laurel (State) Md.

23 FUNERAL DIRECTOR'S SIGNATURE John J. Toner Jr.

ADDRESS Children's Center Laurel, Maryland

24a. REC'D BY REGISTRAR DATE MAY 26 '61

24b. REGISTRAR'S SIGNATURE Curtis L. Hayes

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5129

CERTIFICATE OF DEATH

Reg Dist. No. 05119

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1019 Smithville Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ISAACS — Middle — Last JOHNSON Jr.

4. DATE OF DEATH: Month May — Day 13 — Year 1961

5 SEX: Male — 6 COLOR OR RACE: Colored — 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: June 12 1900 — 9 AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook-U.S.Naval Hospital
10b KIND OF BUSINESS OR INDUSTRY: ———
11 BIRTHPLACE (State or foreign country): Annapolis, Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: ISAACS JOHNSON Sr.
14. MOTHER'S MAIDEN NAME: BLANCHE STEPNEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
INFORMANT: ISAACS JOHNSON Sr.-414 Chesapeake Ave. Address: Annapolis, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b): Coronary Artery Disease — 2 days

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from May 11, 1961, to May 13, 1961, that I last saw the deceased alive on May 13, 1961, and that death occurred at 1:20 a.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore K. Johnson MD — M D
ADDRESS (Street, city or town, state): Calvert Street Annapolis, Maryland
DATE SIGNED
PHYSICIAN'S NAME (Type): T.H.JOHNSON

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 5-16-61
22c NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d LOCATION (City, town or county) (State): Annapolis, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: C.E.HICKS III
ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: MAY 2 61
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 HOURS after death

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5130 — 65120

1 PLACE OF DEATH a. COUNTY [illegible] MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE [illegible] b. COUNTY [illegible]

b. CITY OR TOWN (If outside corporate limits, write "RURAL" and give nearest town) [illegible]

c. LENGTH OF STAY IN 1b [illegible]

c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) [illegible]

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

d. STREET ADDRESS [illegible]

1a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First [illegible] Middle [illegible] Last [illegible]

4 DATE OF DEATH Month [illegible] Day [illegible] Year 1961

5 SEX [illegible] 6 COLOR OR RACE [illegible] 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8 DATE OF BIRTH [illegible]

9 AGE (In years last birthday) [illegible] yrs IF UNDER 1 YEAR Months [illegible] Days [illegible] IF UNDER 24 HRS Hours [illegible] Min [illegible]

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]

10b. KIND OF BUSINESS OR INDUSTRY [illegible]

11. BIRTHPLACE (State or foreign country) [illegible]

12 CITIZEN OF WHAT COUNTRY? A

13 FATHER'S NAME [illegible]

14 MOTHER'S MAIDEN NAME [illegible]

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) [illegible] (If yes, give war or dates of service) [illegible]

16. SOCIAL SECURITY NO [illegible]

17 INFORMANT [illegible] Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b) Mitral insufficiency — 6 months

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) Hypertension — 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) [illegible]

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) [illegible]

20c. TIME OF INJURY Month [illegible] Day [illegible] Year 19 [illegible] Hour [illegible] a.m. p.m. 20d INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) [illegible] 20f (City or town) [illegible] (County) [illegible] (State) [illegible]

21 I certify that (I) (this hospital) attended the deceased from August 1, 1960 to May 16, 1961 that (I) (we) last saw the deceased alive on May 16, 1961, and that death occurred at 8:20 A.M. from the causes and on the date stated above.

22a SIGNATURE [illegible] M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ 22b. DATE SIGNED May 18, 1961

22c. PHYSICIAN'S NAME (Type) Theodore H. Johnson, M. D. 22d ADDRESS 37 Calvert St., Annapolis, Maryland

23a BURIAL CREMATION REMOVAL (Specify) [illegible] 23b. DATE THEREOF [illegible] 23c. NAME OF CEMETERY OR CREMATORY [illegible] 23d LOCATION (City, town or county) [illegible] (State) [illegible]

24. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS [illegible]

25a RECD BY REGISTRAR DATE [illegible] 25b REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9-59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5131

CERTIFICATE OF DEATH

Reg. Dist. No. 05121

1 PLACE OF DEATH
a. COUNTY A. A. Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annap
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 Maryland ave

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md b. COUNTY A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco Park Md
d. STREET ADDRESS 207 Maryland ave e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Mary Middle: S. Plater Last: Jones
4. DATE OF DEATH Month: May Day: 21 Year: 19 61

5. SEX F
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH April 24 1878
9. AGE (In years last birthday) 83 yrs
IF UNDER 1 YEAR: Months / IF UNDER 24 HRS: Days / Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME Michael Worden
14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Mary M. Saunders 16-4 Hamm

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary occlusion	1 day.
DUE TO (b)	Hypertension	Unk.
DUE TO (c)	Arterio-sclerosis	Unk.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 27 Apr, 1949, to 21 May, 1961, that I last saw the deceased alive on 21 May, 1961, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Ronald Brightstone M.D. ADDRESS (Street, city or town, state) 501 Cherry Hill Road DATE SIGNED

PHYSICIAN'S NAME (Type) Ronald Brightstone Jr Baltimore-25 Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF 5-25-61
22c. NAME OF CEMETERY OR CREMATORY Mt Auburn
22d. LOCATION (City or town, or county) (State) Baltimore Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1348 N. Calhoun St

24a. REC'D BY REGISTRAR DATE MAY 23 '61
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5132

Reg. Dist. No. 0512

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 121 West Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 121 West Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAWRENCE — Middle E — Last KING

4. DATE OF DEATH: Month MAY — Day 25 — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 3, 1912

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR — Months — Days
IF UNDER 24 HRS. — Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: General repair

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph W. King

14. MOTHER'S MAIDEN NAME: Mattye E.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs Jane Louise Jones- Sister- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac. — INTERVAL BETWEEN ONSET AND DEATH: Sudden.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Linhardt M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Elmer G. Linhardt

DATE SIGNED: 5/29/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 27, 1961

22c. NAME OF CEMETERY OR CREMATORY: Edwards Chapel Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: MAY 29 '61

24b. REGISTRAR'S SIGNATURE: Luther S. Krause

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute immediately, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5133

Reg. Dist. No. 05123

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 13 Years
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 215 Kent Road, Glen Gardens

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle C. Last Knight

4. DATE OF DEATH: Month May Day 22rd. Year 1961 19

5 SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 2/7/78
9 AGE (n years last birthday): 83 yrs
IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired sheet metal
10b. KIND OF BUSINESS OR INDUSTRY: worker
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Knight
14 MOTHER'S MAIDEN NAME: Elizabeth Gregory

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown), (If yes, give war or dates of service): National Guard
16. SOCIAL SECURITY NO: 214-03-7180
INFORMANT Address: Miss Irma Knight (daughter)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hypertensive cardio-vascular diseases — INTERVAL BETWEEN ONSET AND DEATH: 2

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a. m / p. m. Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 11th. 1961 to May 22rd 1961, that I last saw the deceased alive on May 22rd. 1961, and that death occurred at 8.30P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — ADDRESS (Street, city or town, state): 5 First Ave. S.E. Glen Burnie, Md. — DATE SIGNED: 5/22/61

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 25th May, 1961
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton
ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: MAY 25 '61
24b REGISTRAR'S SIGNATURE: Wilbur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5134

CERTIFICATE OF DEATH

05124

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, so state)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL - Millersville
d. STREET ADDRESS: P.O. Box-70
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: P. — Last: KOCUR

4. DATE OF DEATH: Month: May — Day: 4 — Year: 19 61

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 21, 1903

9. AGE (In yrs. last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. CITIZEN OF WHAT COUNTRY? U.S.

12. FATHER'S NAME: Anthony Struzykowski

13. MOTHER'S MAIDEN NAME: Apolonia Dziadoszek

14. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service): no

15. SOCIAL SECURITY NO.:

16. INFORMANT: Mr.Leon Kocur, Route 3, Box 70, Millersville Md

17. ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Y[illegible]

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I. Please print.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Y 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (State)

20g. I certify that I [illegible] attended the deceased from May 3, 1961 to May 3, 1961 that (I) (XX) last saw the deceased alive on May 3, 1961 and that death occured at 1:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. XX — MED DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 5/4/61

22c. PHYSICIAN'S NAME (Type): Richard N. Peeler

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/8/61

23c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus

23d. LOCATION (City or town) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: M.F.SADOWSKI & SONS, 1808 EASTERN AVE

25a. RECEIVED BY REGISTRAR (Date): MAY 8 61

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed with [illegible] hours after death. [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5135

CERTIFICATE OF DEATH

Reg. Dist. No. 05125

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis (rural)
c LENGTH OF STAY IN 1b: 11 Years
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rt. 2 Box 302

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Maryland — b COUNTY: Anne Arundel
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (rural) Annapolis
d STREET ADDRESS: Rt. 2 Box 59[illegible]
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Clara — Middle: M. — Last: Kuhn

4. DATE OF DEATH: Month: May — Day: 18, — Year: 19 61

5 SEX: Female
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 3rd. June 1876
9 AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H[illegible] (Ret.)
10b KIND OF BUSINESS OR INDUSTRY: Own H[illegible]
11 BIRTHPLACE (State or foreign country): [illegible]shire, Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albin Owings
14. MOTHER'S MAIDEN NAME: Margery Plummer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): ———
16 SOCIAL SECURITY NO.: N.G.
INFORMANT: Mrs M[illegible]y Thal — Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: (Unknown)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Month / Day, Year / Hour a m p m / 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from Sept. ——, 19 58, to May 18, 19 61 that I last saw the deceased alive on April 30, 19 61, and that death occurred at 5:30 a.m. p.m., from the causes and on the date stated above

ACTUAL SIGNATURE: Francis I. Codd, M.D.
ADDRESS (Street, city or town, state): P.O. Box 289
DATE SIGNED: May 15, 1961

PHYSICIAN'S NAME (Type): Francis I. Codd, M.D. — Severna Park, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: May [illegible] 1961
22c NAME OF CEMETERY OR CREMATORY: [illegible]
22d LOCATION (City, town, or county) (State): [illegible]

23 FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible]
24a REC'D BY REG STRAR DATE: MAY 2 • '61
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5136

Reg. Dist. No 05128

1 PLACE OF DEATH
a. COUNTY A. A. Co. MARYLAND

b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberstone

c. LENGTH OF STAY IN 1b 15 yrs

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberstone

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print) First: John Middle: Lansdale

4. DATE OF DEATH Month: May Day: 2 Year: 1961

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH 6-24-82

9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Executive

10b. KIND OF BUSINESS OR INDUSTRY Railroad

11 BIRTHPLACE (State or foreign country) Tridelphia Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME Thos. Franklin Lansdale

14 MOTHER'S MAIDEN NAME Eliza Strain

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI

16 SOC AL SECURITY NO

17 INFORMANT John Lansdale Jr Address Cleveland Ohio

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis

DUE TO (b) Pulmonary Edema

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

177 X

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to May 2nd, 19 61, that I last saw the deceased alive on May 2nd, 19 61, and that death occurred at _____ M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE Emily H. Wilson M.D.

PHYSICIAN'S NAME (Type) Emily H. Wilson M.D. Lothian Maryland

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b DATE THEREOF May 5 1961

22c NAME OF CEMETERY OR CREMATORY

22d LOCATION (City, town or county) (State)

23 FUNERAL DIRECTOR'S SIGNATURE and ADDRESS

24a REC'D BY REGISTRAR DATE MAY 8 '61

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The hospital or attending physician may be fined for failure to do so.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5137

CERTIFICATE OF DEATH

Reg. Dist. No. 15127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH — a COUNTY: [illegible] — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible]
c. LENGTH OF STAY IN 1b: [illegible]
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: [illegible]

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a STATE: [illegible] — b COUNTY: [illegible]
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible]
d STREET ADDRESS: [illegible]
e IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First [illegible] Middle [illegible] Last [illegible]
4 DATE OF DEATH: Month [illegible] Day [illegible] Year 19[illegible]

5. SEX: [illegible]
6 COLOR OR RACE: [illegible]
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: [illegible] 1894
9 AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months [illegible] Days [illegible]
IF UNDER 24 HRS.: Hours [illegible] Min [illegible]

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]
10b KIND OF BUSINESS OR INDUSTRY: [illegible]
11 BIRTHPLACE (State or foreign country): [illegible]
12 CITIZEN OF WHAT COUNTRY?: [illegible]

13 FATHER'S NAME: [illegible]
14 MOTHER'S MAIDEN NAME: [illegible]

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service): [illegible]
16 SOCIAL SECURITY NO: [illegible]
17 INFORMANT: [illegible] Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): [illegible]
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): [illegible]
DUE TO
(c): [illegible]

INTERVAL BETWEEN ONSET AND DEATH: [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): [illegible]

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): [illegible]
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19[illegible]
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): [illegible]
20f (City or town) (County) (State): [illegible]

21. I certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D.
ADDRESS (Street, city or town, state): [illegible]
DATE SIGNED: [illegible]
PHYSICIAN'S NAME (Type): [illegible]

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 5/24/41
22c NAME OF CEMETERY OR CREMATORY: [illegible]
22d LOCATION (City, town, or county) (State): [illegible]

23 FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE MAY 24 [illegible]
24b REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5138 05128

1. PLACE OF DEATH
a. COUNTY: Anne Arundle
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis Md
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Annapolis Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Isle Beach
d. STREET ADDRESS: Riva, Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle E. Last Long

4. DATE OF DEATH: Month May Day 28, Year 19 61

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 28, 1890

9. AGE (In years last birthday): 71 yrs. If UNDER 1 YEAR or UNDER 24 HRS. Months, Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bricklayer

10b. KIND OF BUSINESS OR INDUSTRY: self

11. BIRTHPLACE (City & State or Foreign country): Washington D C

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Jacob A Long

14. MOTHER'S MAIDEN NAME: Mary E unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): yes 1920-1921

16. SOCIAL SECURITY NO.

17. INFORMANT: Elizabeth C. Long Address: Riva, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [illegible]

DUE TO (b) [illegible]

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) [illegible]

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible], and that death occured at [illegible] M, from the causes and on the date stated above

22a. SIGNATURE [illegible] M.D.

ATTEND NG PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 28, 1961

22c. PHYSICIAN'S NAME (Type): Edith Rodler

22d. ADDRESS: Annapolis Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 31, 1961

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

23d. LOCATION (City, town or county, State): Colmar Manor, Md,

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: MAY 31 '61

25b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed [illegible] hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5139 Items 8 & 9 Filed 5/10/61 05129

1 PLACE OF DEATH a. COUNTY: Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis c. LENGTH OF STAY IN MARYLAND: 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

e. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel c. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town: RURAL -- Severn d. STREET ADDRESS: Box-342, Old Quarterfield Road e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Gilbert Middle: Last: LOWMAN

4. DATE OF DEATH: Month: May Day: 4 Year: 1961

5. SEX: Male 6. COLOR OR RACE: White 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] 8. DATE OF BIRTH: June 19, 1896

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur 10b. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (City & State) Foreign country: Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wm Lowman 14. MOTHER'S MAIDEN NAME: UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT (If yes give war or dates of service) Address: Mrs Charlotte Lowman, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause on line (a).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary

DUE TO (b) Cor. Sclerosis

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Cerebral Hemorrhage

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19 20d. INJURY OCCURRED While at work [ ] Not While at work [ ] 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town County State)

21. I certify that (I) [redacted] attended the deceased from ..... 19 ... to .. May 4, 1961 that (I) (XXX) last saw the deceased alive on .. May 4, 1961, and that death occurred at 10:30 P.M. from the causes and on the date stated above

22a. SIGNATURE [signature] M.D. ATTENDING PHYS [XX] MED DIRECTOR [ ] STAFF PHYS [ ] 22b. DATE SIGNED 5/5/61

22c. PHYSICIAN'S NAME (Type) Maurice Klawans 22d. ADDRESS 31 Southgate Ave., Annapolis, Md.

23a. BURIAL CREMATION REMOVAL Specify BURIAL 23b. DATE THEREOF 5-8-61 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. 23d. LOCATION (City town or county State) Balto 25 Md

24. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS Hopping & Kirkley, Glen Burnie

25a. REC'D BY REGISTRAR DATE MAY 9 '61 25b. REGISTRAR'S SIGNATURE Chelsea S. Howard

TO HAVE BURIAL-TRANSIT PERMIT: The law requires that the death certificate be executed with [redacted] hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5140

CERTIFICATE OF DEATH

05130

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 16
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give name of town): Annapolis
d. STREET ADDRESS: 141 Conduit St.
e. DID RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Helen — Middle: N. — Last: MANDRIS
4. DATE OF DEATH: Month: May — Day: 25 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 5 8 1894
9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 1 DAY Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. CITIZEN OF WHAT COUNTRY? Greece
12. [illegible]: 45
13. FATHER'S NAME: Dimetrius Apostolakis
14. MOTHER'S MAIDEN NAME: Georgia ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give war or date of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Nick J. Mandris

I

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL ILLNESS OR CONDITION GIVEN IN PART I
AUTOPSY PERFORMED YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town only

21. I certify that I (~~XXXXXXXX~~) attended the deceased from May 25, 1961 to May 25, 1961 that (I) (~~XXX~~) last saw the deceased alive on May 25, 1961 and that death occurred at 5:30 P.M. from the causes and on the date stated above
22a. SIGNATURE: [illegible] Martin
22b. DATE SIGNED
ATTENDING PHYS. MD [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. PHYSICIAN'S NAME (Type): James R. Martin
22d. ADDRESS: 6 Shaw St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-29-61
23c. NAME OF CEMETERY OR CREMATORY: St. Thomas
23d. LOCATION City, town or county: Hanover Pike
24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] Funeral Home
ADDRESS
25a. RECEIVED BY REGISTRAR: MAY 29 61
25b. REGISTRAR'S SIGNATURE: Esther L. Krauss
DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5141

05131

1 PLACE OF DEATH
a. COUNTY [illegible] MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]

c. LENGTH OF STAY IN 1b [illegible]

c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Glen Burnie, Md

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

d. STREET ADDRESS [illegible]

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Lily Middle: Sperit Last: Mawshaw

4. DATE OF DEATH Month: May Day: 2 Year: 19[illegible]

5. SEX [illegible]

6. COLOR OR RACE [illegible]

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH [illegible]

9. AGE (In years last birthday) [illegible] yrs

IF UNDER 1 YEAR IF UNDER 24 HRS Months [illegible] Days [illegible] Hours [illegible] Min [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY [illegible]

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Joseph [illegible]

14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO [redacted]

17. INFORMANT [illegible] Address 7 Richardson Blvd

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]

PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) [illegible]

DUE TO (b) Anemia

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO (c) Internal Damage

INTERVAL BETWEEN ONSET AND DEATH [illegible] 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m p. m 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible], 19[illegible] and that death occurred at [illegible] M, from the causes and on the date stated above.

22a. SIGNATURE [illegible] M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED [illegible]

22c. PHYSICIAN'S NAME (Type) [illegible]

22d. ADDRESS Burnie

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF [illegible]

23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery

23d. LOCATION (City, town, or county) (State) 5029 Ritchie Hwy. Maryland

24. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS [illegible]

25a. REC'D BY REGISTRAR DATE MAY 4 '61

25b. REGISTRAR'S SIGNATURE Evelyn S. Kraas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be [illegible] the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

M

T

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5142 — 05132

1. PLACE OF DEATH
a. COUNTY: A.A Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A-Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived, If institution, ...)
a. STATE: MD
b. COUNTY: AA Co.
c. CITY OR TOWN (If outside corporate limits write RURAL and give ...): Annapolis — MD
d. STREET ADDRESS: 236 Westwood Rd
RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: B; Last: Mitchell
DATE OF DEATH: Month: 5; Day: 25; Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 8 1905
9. AGE (In years last birthday) IF UNDER 1 YEAR OR UNDER 1 DAY: 56 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock broker
10b. KIND OF BUSINESS OR INDUSTRY: Stocks+Bonds
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: Charles B Mitchell
14. MOTHER'S MAIDEN NAME: Mary Ellen Kirby
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service): Yes WWII
16. SOCIAL SECURITY NO.:
17. INFORMANT: Chas. B. Mitchell III — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cancer
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt
EXAMINER'S NAME (Type): E. Linhardt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county)
DATE SIGNED: 5/25/61

22a. BURIAL, CREMATION, REMOVAL (specify): Burial
22b. DATE THEREOF: 5/27/61
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park
22d. LOCATION (City, town, or county): Baltimore Md.

23. FUNERAL DIRECTOR: John M Hayes + Sons
ADDRESS: Annapolis, Md

24a. RECEIVED BY REGISTRAR: MAY 29 61
DATE
24b. REGISTRAR'S SIGNATURE: Arthur S Kruse

TO DEL... MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a ... necessary, please e... the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the ... rector. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5145 — 05133

1. PLACE OF DEATH
a. COUNTY: Baltimore — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cedar Hill
c. LENGTH OF STAY IN b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 308 Snow Hill Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL): Cedar Hill
d. STREET ADDRESS: 308 Snow Hill Road - #25
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Margery — Middle: L. — Last: Mitchell

4. DATE OF DEATH: Month: May — Day: 28 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: April 20, 1887

9. AGE (In years. IF UNDER 1 YEAR last birthday. Months / Days / IF UNDER 24 HRS Hours / Min): 74 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City & State or Foreign Country): Anne Arundel Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard T. Williams

14. MOTHER'S MAIDEN NAME: Sarah J. Henson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 215-07-9649

17. INFORMANT: Luvinia Hall

Address: 306 Snow Hill Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Occlusion

DUE TO (b): Broncho-genic Carcinomata & Mstastases

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Day / Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town — County — State

21. I certify that (I) (this hospital) attended the deceased from 2-10, 1961 to 5-28-, 1961 that (I) (we) last saw the deceased alive on 5-28-, 1961, and that death occured at 5:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard H. Hunt

M.D. ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5-29-61

22c. PHYSICIAN'S NAME (Type): RICHARD H HUNT

22d. ADDRESS: 100 Cherry Lane, Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-1-61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

23d. LOCATION (City, town or county / State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Charles L Law

ADDRESS: 802 Madison Ave. Baltimore, Md.

25a. REC'D BY REGISTRAR DATE: MAY 3 '61

25b. REGISTRAR'S SIGNATURE: W. H. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5144

CERTIFICATE OF DEATH

Reg. Dist. No. 05134

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Homewood Convl, Home

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b COUNTY: Anne Ar no l
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d STREET ADDRESS: 109 Roselawn Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒X

3 NAME OF DECEASED (Type or print): First PEARL Middle STEVENS Last MITCHELL

4. DATE OF DEATH: Month MAY Day 24 Year 19 61

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: March 17, 1888
9 AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b KIND OF BUSINESS OR INDUSTRY: own home
11 BIRTHPLACE (State or foreign country): Annapolis, Maryland
12 CITIZEN OF WHAT COUNTRY: USA

13 FATHER'S NAME: John Franklin Stevens
14 MOTHER'S MAIDEN NAME: Mary Anna Gates

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16 SOCIAL SECURITY NO: none
17 INFORMANT: Mr John F. Mitchell- Son- same as # 2 Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): [illegible]
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE [illegible] M.D.

PHYSICIAN'S NAME (Type) Edward S. Beck MD 71 Franklin Street, Annapolis, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: May 27,61
22c NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hopping Funeral Home Annapolis, Maryland
24a. RECD BY REGISTRAR DATE: MAY 29 '61
24b REGISTRAR'S SIGNATURE: Clifton S. Mans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5145 — 65135

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution or R.F.D. residence, give location)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL - Annapolis
d. STREET ADDRESS: Rt-2, Box-366 (St. Margarets)
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Fran — Middle: Hannah — Last: MURRAY

4. DATE OF DEATH: Month: May — Day: 9 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 6, 1961

9. AGE (In years last birthday) IF UNDER 1 YEAR: Months: 3 — IF UNDER 1 DAY: Hours: 13 — Min.: 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Elmer Joseph MURRAY

14. MOTHER'S MAIDEN NAME: Florence Geneva GREEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Hospital records.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sepsis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Maternal eclampsia — 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town — County

21. I certify that (I) ~~XXXXXXXX~~ attended the deceased from May 6, 1961 to May 9, 1961, that (I) ~~(XX)~~ last saw the deceased alive on May 9, 1961, and that death occured at 1:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Stuart H. Walker M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Stuart H. Walker

ATTENDING PHYS. [XX] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/13/1961

23c. NAME OF CEMETERY OR CREMATORY: Brookmere

23d. LOCATION (City, town, or county, state): Baltimore Md.

24. FUNERAL DIRECTOR'S SIGNATURE: William Mc H. Allen Jr.

ADDRESS

25a. REC'D BY REGISTRAR DATE: MAY 17 '61

25b. REGISTRAR'S SIGNATURE: Carlton S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 PLACE OF DEATH — 5146 — 05136

a. COUNTY: Anne Arundel — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

c. LENGTH OF STAY IN 1b: 15 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, use last residence.)

a. STATE: Maryland — b. COUNTY: Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL): Glen Burnie

d. STREET ADDRESS: 604 Stewart Ave.,

e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Robert — Middle: — Last: NEVIN

DATE OF DEATH: Month: May — Day: 9 — Year: 1961

4. SEX: Male

5. COLOR OR RACE: White

6. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

7. DATE OF BIRTH: Sept. 16, 1885

8. AGE (In years last birthday): 75 yrs.

9. IF UNDER 1 YEAR: Months: — Days: — Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Florist

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (City & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Nevin

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Thomas Nevin, Address: Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 14 DAYS

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: DIABETES MELLITUS, DIABETIC GANGRENE — WAS AUTOPSY PERFORMED? YES [ ] NO [XX]

19a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or II of Item 18):

19c. TIME OF INJURY: Hour: — a.m. / p.m. — Month: — Day: — Year: 19

19d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

19e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

19f. City or town: — County: — (State): —

21. I certify that I (XXXXXX) attended the deceased from April 24, ..., 1961, to May 8, , 1961. Saw (I) (XX) last saw the deceased alive on May 8, 1961, and that death occured at 2:40 A.M. from the causes and on the date stated above.

22. SIGNATURE OF PHYSICIAN'S NAME (Type): Edward S. Beck, M.D. — ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED: 5/9/61

22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-12-61

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City, town or county): Glen Burnie — (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hopping & Kirkley, Glen Burnie

25a. RECD BY REGISTRAR DATE: MAY 18 '61

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5147

Reg. Dist. No. 5137

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DAVIDSONVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DAVIDSONVILLE
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ROBERT — Middle DARVELL — Last O'DELL
4. DATE OF DEATH: Month 5 — Day 7 — Year 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 1-28-1941
9. AGE (In years last birthday): 20 yrs.
IF UNDER 1 YEAR: Months — Days. IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ROBERT O'DELL
14. MOTHER'S MAIDEN NAME: ELLEN SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: —
17. INFORMANT: ROBERT O'DELL — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible]
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 7 / 20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. L. WARD
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 5/7/61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5-9-61
22c. NAME OF CEMETERY OR CREMATORY: HILLCREST
22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: MAY 10 61
24b. REGISTRAR'S SIGNATURE: Clarke J. Mc

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute [illegible] office, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director who will forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Page 4 should be TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1SME(S)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05138

1. PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) [illegible]

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE Md. b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
d. STREET ADDRESS [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First [illegible] Middle [illegible] Last [illegible]
4. DATE OF DEATH Month May Day 18 Year 1961

5. SEX F
6. COLOR OR RACE [illegible]
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH [illegible]
9. AGE (in years last birthday) 57 yrs. If UNDER 1 YEAR Months Days If UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]
10b. KIND OF BUSINESS OR INDUSTRY [illegible]
11. BIRTHPLACE (City or Town & State or foreign country) [illegible]
12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME [illegible]
14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT [illegible] Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b and c.)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO (b) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH
2 yrs
20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, item)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb, 1950 to 18 May 1961, that (I) (we) last saw the deceased alive on 16 May 1961, and that death occured at.....M, from the causes and on the date stated above

22a. SIGNATURE [signature]
22b. DATE SIGNED
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF May 20 1961
23c. NAME OF CEMETERY OR CREMATORY [illegible]
23d. LOCATION (City, town or county) (State) [illegible]

24. FUNERAL DIRECTOR'S SIGNATURE [illegible]
ADDRESS [illegible]

25a. REC'D BY REGISTRAR DATE JUN 2 '61
25b. REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with[illegible] hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5149

CERTIFICATE OF DEATH

Reg. Dist. No. 0513

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 121 Farragut Rd.

2 USUAL RESIDENCE (Where deceased lived. If inst tut on Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and g ve nearest town): Annapolis 10
d STREET ADDRESS: 121 Faragut Rd.
e. S RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First OWEN Middle FREDERICK Last PHIPPS

4. DATE OF DEATH: Month May Day 9, Year 19 61

5 SEX: Male
6 COLOR OR RACE: White
7. MARRIED ☒ NEVER MARR ED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF B RTH: Oct. 1, 1910
9 AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired): Truck Mechanic
10b KIND OF BUSINESS OR INDUSTRY: Beverage Company
11 BIRTHPLACE (State or foreign country): A.A. County, Maryland
12 CITIZEN OF WHAT COUNTRY: USA

13 FATHER'S NAME: Walter Phipps
14 MOTHER'S MAIDEN NAME: Maude McCoy

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): n9
16. SOCIAL SECURITY NO: 214 05 1359
17 INFORMANT: Mrs Ethel Virla hipps- Wife- Address: same as # 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Hours (2)
DUE TO (b): Arteriosclerotic Cardiovascular
DUE TO (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART II. OTHER S GN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a. m / p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from May 5, 1961, to May 9, 1961, that I last saw the deceased alive on May 4, 1961, and that death occurred at 7 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F. Klawans, M.D.
ADDRESS (Street, city or town, state): 31 Southgate Ave., Annapolis, Md.
DATE SIGNED: 5/10/61
PHYSICIAN'S NAME (Type): Maurice F. Klawans MD — 31 Southgate Ave., Annapolis, Maryland

22a BURIAL, CREMAT ON, REMOVAL (Spec fy): Burial
22b DATE THEREOF: May 11, 1961
22c NAME OF CEMETERY OR CREMATORY: All Hallows
22d LOCATION (City town or county) (State): Birdsville, Maryland

23 FUNERAL DIRECTOR S SIGNATURE: Hopping Funeral Home
ADDRESS: Annapolis, Md.
24a REC'D BY REGISTRAR DATE: MAY 15 '61
24b REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5150 05140

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Resident, give last usual residence)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Annapolis
d. STREET ADDRESS: Rt-1, Box-68
RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or Print): First CHARLES Middle FRANK Last PRENTISS

4. DATE OF DEATH: Month May Day 29 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 25, 1896

9. AGE In years (If under 1 year, months, days, or hours) Last birthday 64 yrs

10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PLUMBER
b. KIND OF BUSINESS OR INDUSTRY: MASTER PLUMBER

11. BIRTHPLACE (State or Foreign Country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William F. Prentiss

14. MOTHER'S MAIDEN NAME: BERTHA CROUSE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): YES WW I

16. SOCIAL SECURITY NO.

17. INFORMANT: CORABEL A. PRENTISS — Address: [illegible] 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE: Cerebral vascular accident
DUE TO (b): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 7 years
DUE TO (c): Hemiplegia right side

(gave rise to immediate cause (a), stating the underlying cause last.)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18): Partial atrio-ventricular block

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.)

20f. City or town (County) (State)

21. I certify that (I) (~~XXXXXXX~~) attended the deceased from ..... , 19 ., to May 29., 1961, that (I) (~~XX~~) last saw the deceased alive on May 29 ..1961.., and that death occured at 8:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edith Rodler, M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Edith Rodler

22d. ADDRESS: 45 Franklin St., Annapolis, Md.

23a. BURIAL ~~CREMATION~~, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 6-2-61 — 23c. NAME OF CEMETERY OR CREMATORY: Annapolis National — 23d. LOCATION (City, town or county): Annapolis — State: Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Son — ADDRESS: Annapolis, Md.

25a. RECD BY REGISTRAR — DATE JUN 2 '61 — 25b. REGISTRAR'S SIGNATURE: Clinton L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with [illegible] hours after death. [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5157 — Item 7 from Dept. — File No. 15141

1 PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.R. #1 - Annapolis
c. LENGTH OF STAY IN this place of death: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. of A. Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived, and not institution. If outside U.S., write FOREIGN.)
a. STATE: M D — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsburg
d. STREET ADDRESS: — RESIDENCE IN CITY? Yes [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Richard — Middle: L. — Last: Ratcliffe
4. DATE OF DEATH: Month: 5 — Day: 7 — Year: 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 3-19-40
9. AGE (In years. If under 1 year, number of months, days, hours, or minutes.): 21 yrs. — Months | Days | Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Easton, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Richard L Ratcliffe
14. MOTHER'S MAIDEN NAME: Hilda Phillips
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 216-38-8572
17. INFORMANT (Name, Address): Richard L Radcliffe, Williamsburg, Md
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture cervical spine
DUE TO (b): Multiple Lacerations
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Auto struck tree - Route # 2
20c. TIME OF INJURY: Hour 4:10 (a.m. / p.m.) — Month, Day, Year: 5-7 1961
20d. INJURY OCCURRED: While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. 2.
20f. (City or town) — (County): A.A. Co. — (State): Md.

21 I certify that I took charge of the remains described above, held an Autopsy [ ] Inspection [X] Inquiry [ ] in my opinion death resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: E. L. Hartsuch M.D.
EXAMINER'S NAME (Type): E. L. Hartsuch
CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: 5-7-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-10-61
22c. NAME OF CEMETERY OR CREMATORY: Tilghman County
22d. LOCATION (City, town or county): Tilghman Md

23. FUNERAL DIRECTOR: L. Hampton Harrison
ADDRESS: St. Michaels Md.
24a. REC'D BY REGISTRAR | DATE: MAY 10 '61
24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO DEPARTMENTAL EXAMINER: This certificate should be executed within 24 hours after death. If a ... necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the ... sector. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5152

CERTIFICATE OF DEATH

05142

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give name of town): Annapolis
c. STREET ADDRESS: 6 ~~Washington~~ MARTIN St.
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hester — Middle: PETTIT — Last: ROBINSON
4. DATE OF DEATH: Month: May — Day: 8 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct-18-1881
9. AGE (In years. If under 1 year, last birthday): 79 yrs. — If under 24 hrs: Months, Days, Hours, Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b KIND OF BUSINESS OR INDUSTRY: Home
11 BIRTHPLACE (City & State or foreign country): New York
12 CITIZEN OF WHAT COUNTRY? U.S.
13 FATHER NAME: Theodore Pettit
14 MOTHER'S MAIDEN NAME: Hester Keyser
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO.
17. INFORMANT: Hester A. Waer — Address: (2)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for a, b and c.)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to death but not related to the terminal disease conditions given in Part I): DIABETES MELLITUS, ARTERIOSCLEROTIC HT. DISEASE, CARCINOMA OF COLON
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a ACCIDENT, WAS UNDETERMINED, OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Refer to item number of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f City or town
County
State

21. I certify that I (XXXXXXX) attended the deceased from , 19 , to May 8, , 1961, that (I) (XXX) last saw the deceased alive on May 8, 1961, and that death occurred at 8:35 P.M. from the causes and on the date stated above
22a SIGNATURE: Edward S Beck — M.D. — ATTENDING PHYS. XX — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b DATE SIGNED: 5/9/61
22c. PHYSICIAN'S NAME (Type): Edward S. Beck
22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 10-1961
23c. NAME OF CEMETERY OR CREMATORY: The Green Wood Cemetery
23d. LOCATION (City, town or county) (State): Brooklyn N. Y.
24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John M. Taylor Sons Annapolis Md.
25a REC'D BY REGISTRAR (DATE): MAY 10 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5153 **CERTIFICATE OF DEATH** 05143

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with... 24 hours after death. ... may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, ... by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN this place: MARYLAND 3 years 6mos. 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Mae; Middle: Bell; Last: Robinson
4. DATE OF DEATH: Month: 5; Day: 27; Year: 19 61
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 1909
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. [illegible]: Unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
I 22.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:
Psychosis Associated with Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS [illegible] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part I. Part II of [illegible]: ------
20c. TIME OF INJURY: Hour a.m. p.m. ------ Month Day Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, factory, street, office bldg. etc.): ------
20f. City or town: ------

21. I certify that (I) (this hospital) attended the deceased from 11/5 ... 19 57 A. to 5/27, 1961 that (I) (we) last saw the deceased alive on 5/27 1961 and that death occured at 6:40 M., from the causes and on the date stated above.

22a. SIGNATURE: L. Benedict
22b. DATE SIGNED: 5/29/61
22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.
M.D. ATTENDING PHYS. [ ] MED DIRECTOR [X] STAFF PHYS. [ ]
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town or [illegible])

24. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS
25a. REC'D BY REGISTRAR DATE MAY 3 '61
25b. REGISTRAR SIGNATURE

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5154 — 05144

1 PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 111 Severn Ave.,

a. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print): First: Catherine; Middle: Anne; Last: SCHENCK

4. DATE OF DEATH: Month: May; Day: 21; Year: 1961

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 18, 1961
9 AGE (In years last birthday): yrs. | IF UNDER 1 YEAR: Months | Days 2 | IF UNDER 2 HRS.: Hours 17 | Min. 5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert Edwin SCHENCK
14. MOTHER'S MAIDEN NAME: Rosanne Catherine DuPLESSIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT: Address: Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Prematurity
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO XX

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (XXXXXXXX) attended the deceased from May 18, 1961 to May 20, 1961, that (I) (XX) last saw the deceased alive on May 20, 1961, and that death occured at 3:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Stuart M. Walker
M.D ATTENDING PHYS [X] MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/23/61
22c. PHYSICIAN'S NAME (Type): Stuart M. Walker
22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/22/1961
23c NAME OF CEMETERY OR CREMATORY: St. Mary's
23d LOCATION (City, town or county): Annapolis
(State): Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John M. Taylor & Sons Annapolis, Md.
25a REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
DATE MAY 25 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5155

CERTIFICATE OF DEATH

05145

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): (Dead on arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Resident of)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 121 Conduit St.
e. RESIDENCE ON FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Virginia; Middle: ; Last: SEARS

4. DATE OF DEATH: Month: May; Day: 4; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [XX] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 10, 1891

9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Nursing

11. CITIZEN OF WHAT COUNTRY?: U.S.

12. BIRTHPLACE (State or foreign country): Maryland

13. FATHER'S NAME: James R. Sears

14. MOTHER'S MAIDEN NAME: Rosie Trott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 6--------

17. INFORMANT: Sears Jesse-Sears; Address: 617 Hamlin St NE Washington, D.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible]
DUE TO (b): [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

AUTOPSY PERFORMED YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part I or Part II of item 18.

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

21. I certify that I (XXXXXXX) attended the deceased from March, 1958 to May 4, 1961 (first (I) XXX) last saw the deceased alive on May 4, 1961 and that death occured at 11:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5/5/61

22c. PHYSICIAN'S NAME (Type): Emily H. Wilson, M.D.

22d. ADDRESS: Lothian, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 7.1961

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion

23d. LOCATION (City or town) (County) (State): Anne Arundel Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons

ADDRESS: Annapolis Md

25a. RECD BY REGISTRAR DATE: MAY 9 '61

25b. REGISTRAR SIGNATURE: Clifford L. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5156 (5146)

1 M I

PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN this place: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL): RURAL — Harwood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Eleanor — Middle: [illegible] — Last: SHEPHERD
4. DATE OF DEATH: Month: May — Day: 16 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 27, 1880
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: C. MORRIS AHEARN
14. MOTHER'S MAIDEN NAME: Sally C Mowday
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wm Shepherd
Address: Harwood Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial insufficiency
DUE TO (b): Diabetes mellitis & arteriosclerosis
DUE TO (c): hypostatic pneumonia

(a), (b), (c), which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

WAS A TOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18:
20c. TIME OF INJURY: Hour, a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY: Home, farm, factory, street, office bldg., etc.
20f. City or town (County) (State)

21. **I certify** that (I) XXXXXXXX attended the deceased from April, 1950, to May 15, 1961, that (I) (XXX) last saw the deceased alive on May 15, 1961 and that death occured at 4:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Emily H. Wilson, M.D.
22b. DATE SIGNED: 5/16/61
22c. PHYSICIAN'S NAME Typed: Emily H. Wilson
ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22d. ADDRESS: Lothian, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS
25a. REC'D BY REGISTRAR DATE: MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5157 05147

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 11 Ridout St.
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: — Last: SIMMS
4. DATE OF DEATH: Month: May — Day: 17 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 10, 1869
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: Elizabeth Hammond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) | (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Address: Lewis Simms Jr. [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b and c.)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Renal Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
WAS AUTOPSY PERFORMED? YES ☐ NO ☒

19a. ACCIDENT, HOMICIDE, SUICIDE, UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
19c. TIME OF INJURY: Hour, a.m./p.m. — Month, Day, Year, 19
19d. INJURY OCCURRED: While at work ☐ Not While at work ☐
19e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19f. City or town — County — State

21. I certify that (I) [illegible] attended the deceased from . , 19. , to May 17, 1961 that (I) (~~did~~) last saw the deceased alive on May 17, 1961, and that death occured at 7:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: A. T. Allen
22b. DATE SIGNED
M.D. ATTENDING PHYS. XX MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): A. T. Allen
22d. ADDRESS: 62 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-20-1961
23c. NAME OF CEMETERY OR CREMATORY: Bureau Hall Cemetery
23d. LOCATION (City, town or county) State:

24. FUNERAL DIRECTOR'S SIGNATURE: William Kiernan
ADDRESS: Glendale Md.

25a. REC'D BY REG. STRAR DATE: MAY 19 '61
25b. REGISTRAR'S SIGNATURE: Clinton B. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5158 — 05148

1. NAME OF DECEASED (Type or Print): EZRA Lee Smart

2. DATE OF DEATH: 5-30-61

3 PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 4914 Brookwood Rd

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MD B. COUNTY: Balto County
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 4914 Brookwood Rd

5 SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9 AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min
F	W	Married	July 11, 1895	65		

10.A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Gov. worker	W. Va	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
UNK	UNK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
NO		Family	Same.

I MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 200.1
(A) Lymphosarcoma, wide-spread. — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19A DATE OF OPERATION	19B CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES ☐ NO ☐

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan 5 19 61 to May 30 19 61, that (I) (~~we~~) last saw the deceased alive on May 29 19 61, and that in (my) (~~our~~) opinion death occurred at 1 50 a.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C DATE SIGNED
Norton M. Krieger M D ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	5th Keyser Hwy - 25.	May 31, 61

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
B	6-2-61	Sugar Creek Cem.	Hagerstown, Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
JUN 1 '61	Miriam L. Thomas	McCulla Funeral Home 120 E. Franklin

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. It must be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal and, in any event, within 72 hours after death.

VR A15 (4)
15M 9/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5159 — Reg. Dist. No. 05149

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CARVEL BEACH
c. LENGTH OF STAY IN 1b: 14 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 320 CARVEL BEACH ROAD

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CARVEL BEACH
d. STREET ADDRESS: 320 CARVEL BEACH ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LLOYD — Middle: WILLIAM — Last: SMITH
4. DATE OF DEATH: Month: MAY — Day: 26 — Year: 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC 18, 1914
9. AGE (In years last birthday): 46 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U S A.

13. FATHER'S NAME: RICHARD TAYLOR SMITH
14. MOTHER'S MAIDEN NAME: MARY POLZIN

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): YES (If yes give war or dates of service): 11/19/43-6/14/45
16. SOCIAL SECURITY NO: 214 01 8965
17. INFORMANT: THELMA SMITH — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	CORONARY THROMBOSIS	Instantaneous
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b)	HYPERTENSIVE CARDIOVASCULAR DISEASE	16 Years
DUE TO (c)	CORONARY SCLEROSIS	16 Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MARCH 3, 1961, to MAY 26, 1961, that I last saw the deceased alive on MAY 20, 1961, and that death occurred at 4:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith, M D — ADDRESS (Street, city or town, state): 3471 Ft. Smallwood Road, Pasadena, Maryland — DATE SIGNED: 5/26/61

PHYSICIAN'S NAME (Type): J BRADY SMITH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5-29-61
22c. NAME OF CEMETERY OR CREMATORY: BALTIMORE NATIONAL
22d. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: GEORGE J. CONCE — ADDRESS: 4001 RITCHIE HGWY.
24a. REC'D BY REGISTRAR DATE: MAY 31 '61
24b. REGISTRAR'S SIGNATURE: Wilbur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled with page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5160

CERTIFICATE OF DEATH

05150

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: Green Briar Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: May; Last: SMITH

4. DATE OF DEATH: Month: May; Day: 29; Year: 1961.

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED WIDOWED X DIVORCED ☐

8. DATE OF BIRTH: Feb. 28, 1884

9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (County & State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Hospital Records — Address: none

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 17 DAYS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: ARTERIOSCLEROSIS, GENERALIZED — Unknown
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (State)

21. I certify that (I) (XXXXXXX) attended the deceased from May 12, 1961, to May 29, 1961, that (I) (XX) last saw the deceased alive on May 29, 1961, and that death occured at 3:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck M.D.
ATTENDING PHYS XX MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Edward S. Beck
22d. ADDRESS: 71 Franklkin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL-REMOVAL
23b. DATE THEREOF: May 30,61
23c. NAME OF CEMETERY OR CREMATORY: Bellevue Memorial Cemet.
23d. LOCATION City, town or county: Daytona Beach, Fla.
St.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: HOPPING FUNERAL HOME, Annapolis, Maryland
25a. REC'D BY REGISTRAR DATE: JUN 1 '61
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ... hours after death. ... may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5161 — 05151

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: MARYLAND 7mos. 3 years 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: ~~South~~ Carolina
c. CITY OR TOWN (If outside corporate limits, write RURAL): Baltimore
d. STREET ADDRESS: 2307 Orem Avenue
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Orabell; Middle: ; Last: Snowden

4. DATE OF DEATH: Month: 5; Day: 23; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: September 8, 1909

9. AGE (In years last birthday) 51 yrs. | IF UNDER 1 YEAR (Months) Days | IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (City or town, State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clay Coleman

14. MOTHER'S MAIDEN NAME: Isabella Burnside

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-30-8433

17. INFORMANT: Hospital Records — Address:

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): 422.1
DUE TO (c): Arteriosclerotic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.: Decubitus Debilitated Condition

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): ------

20c. TIME OF INJURY: Hour a.m. p.m. ----- Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] While not at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ------

20f. (City or town) (County) (State): ------

21. **I certify** that (I) (this hospital) attended the deceased from 10/1 ....., 19 57, to 5/23 ....., 19 61, that (I) (we) last saw the deceased alive on 5/23 ....., 1961, and that death occured at 6P.M. from the causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5/24/61

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 5-27-61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery

23d. LOCATION (City, town or county) State: Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]

ADDRESS: [illegible]

25a. REC'D BY REGISTRAR DATE: MAY 25 '61

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ● hours after death. ● may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5162

05152

1. PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b [illegible]
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Maryland
b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) [illegible]
d. STREET ADDRESS [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First [illegible] Middle [illegible] Last [illegible]

4. DATE OF DEATH Month [illegible] Day [illegible] Year 19[illegible]

5. SEX [illegible]
6. COLOR OR RACE [illegible]
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH [illegible]
9. AGE (In years last birthday) [illegible] yrs
IF UNDER 1 YEAR Months [illegible] Days [illegible]
IF UNDER 24 HRS Hours [illegible] Min [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]
10b. KIND OF BUSINESS OR INDUSTRY [illegible]
11. BIRTHPLACE (State or foreign country) Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [illegible]
14. MOTHER'S MAIDEN NAME Katherine [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service) [illegible]
16. SOCIAL SECURITY NO [illegible]
17. INFORMANT [illegible] Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute Cardiac Failure
DUE TO (b) Chronic Arteriosclerotic Hypertension
DUE TO (c) [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-16 19[illegible] to April 19[illegible] that (I) (we) last saw the deceased alive on 4-25 1961, and that death occurred at 8:30 A.M. from the causes and on the date stated above

22a. SIGNATURE C. R. McDonald M.D.
22b. DATE SIGNED [illegible]
ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22c. PHYSICIAN'S NAME (Type) [illegible]
22d. ADDRESS [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify) [illegible]
23b. DATE THEREOF 1st May 1961
23c. NAME OF CEMETERY OR CREMATORY Woodlawn (Crem.)
23d. LOCATION (City, town, or county, State) [illegible]

24. FUNERAL DIRECTOR'S SIGNATURE [illegible]
ADDRESS [illegible]
25a. REC'D BY REGISTRAR DATE MAY 10 61
25b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5163 — 05153

1 (M) (I)

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN this place: 7 years 2mos. 7days
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give ward): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, last residence before admission.)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL): Baltimore
d. STREET ADDRESS: 317 E. 22nd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward; Middle: ; Last: Vann

4. DATE OF DEATH: Month: 5; Day: 2; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October, 1873

9. AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hr ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. CITIZEN OF WHAT COUNTRY? North Carolina

12. U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO: b. Nephrosclerosis, Arterial
Conditions if any which gave rise to immediate cause (a) stating the underlying cause last
DUE TO: c. Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Chronic Brain Syndrome c Generalized Arteriosclerosis

WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

19. ACCIDENT, WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Violence, injury, Part I or Part II, Item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21. I certify that I (this hospital) attended the deceased from 2/25 19 54 to 5/2 19 61 that I (we) last saw the deceased alive on 5/2 19 61, and that death occurred at 2:08 P M, from the causes and on the date stated above.

22a. SIGNATURE: L. Benedict

22b. DATE SIGNED: 5/2/61

M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☒ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22d. ADDRESS: Crownsville State Hospital, [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/4/61

23c. NAME OF CEMETERY OR CREMATORY: Marion

23d. LOCATION (Town or City): Philadelphia P.A.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]

ADDRESS: 938 E. North Ave. Maryland Mortuary 638 N. Gilmor St

25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE

DATE MAY 8 '61 | Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completed in by the funeral director within 24 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5164 — 05154

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 34 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S.Naval Hospital, Annapolis, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 16 Spa View Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Winfield Last: VANOUS

4. DATE OF DEATH: Month: May Day: 14 Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 23 April 1909

9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Naval Officer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: William J. VANOUS

14. MOTHER'S MAIDEN NAME: Daisy Elizabeth SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) Yes (If yes give war or dates of service) WW II

16. SOCIAL SECURITY NO.

17. INFORMANT: Katherine B. VANOUS Address: 16 Spa View Avenue, Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMA, Liver, Widespread — INTERVAL BETWEEN ONSET AND DEATH: 72 Weeks

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10 April, 1961, to 14 May, 1961, that (I) (we) last saw the deceased alive on 14 May 1961 and that death occured at 3:25p from the causes and on the date stated above

22a. SIGNATURE: N. Zouras — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): N. (n) ZOURAS, LT MC USNR

22d. ADDRESS: U.S.Naval Hospital, Annapolis, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-17-61

23c. NAME OF CEMETERY OR CREMATORY: U.S. NAVAL ACADEMY

23d. LOCATION (City, town or county) (State): ANNAPOLIS MD.

24 FUNERAL DIRECTOR'S SIGNATURE: JOHN M. TAYLOR SON — ADDRESS: ANNAPOLIS MD

25a REC'D BY REGISTRAR DATE: MAY 17 '61

25b REGISTRAR'S SIGNATURE: Charlton S. Flowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5165 — 05155

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN ME: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence b[illegible]
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give n[illegible]: RURAL – Severn
STREET ADDRESS: Old Oak Road
e. IS RESIDENCE ON A FARM? YES [ ] NO [ ]

3. NAME OF DECEASED (Type or print): First: Patsy; Middle: (Pasquale); Last: VARIALI

4. DATE OF DEATH: Month: May; Day: 29; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] DIVORCED [X] XXXXXXX

8. DATE OF BIRTH: May 17, 1895

9. AGE (In years if 1 year or over; If under 1 year, months; If under 1 month, days): 66 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Storekeeper (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Self Emp.

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Natalie Variali

14. MOTHER'S MAIDEN NAME: Louise (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: //////////

17. INFORMANT: unknown

Address: Mrs. Phylis Variali — Same As #2

18. CAUSE OF DEATH (Enter only one cause per line for a, b and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 hours
DUE TO (b): Hypertension — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.); City or town; County; State

21. I certify that (I) (XXXXXXXX) attended the deceased from May 29, 1961 to May 29, 1961 that (I) (XX) last saw the deceased alive on May 29, 1961, and that death occured at 7:40 A.M. from the causes and on the date stated above

22a. SIGNATURE: Richard I. Hochman — M.D. — ATTENDING PHY. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5/29/61

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman

22d. ADDRESS: 100 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2nd. June '61

23c. NAME OF CEMETERY OR CREMATORY: St. Bernards Ch. Cem.

23d. LOCATION (City, town or county; State): Indiana, Pennsylvania

24. FUNERAL DIRECTOR'S SIGNATURE: Richard T. Taylor

ADDRESS: GlenBurnie, Maryland

25a. REC'D BY REGISTRAR (DATE): JUN 1 '61

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M I 050 O

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5166

CERTIFICATE OF DEATH

Reg. Dist. No. U5156

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEORGE G MEADE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT GEORGE G MEADE
d. STREET ADDRESS: Quarters # 2682-B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOROTHY Middle MURTAGH Last WHITE

4. DATE OF DEATH: Month MAY Day 31 Year 19 61

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10 May 1908

9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: –

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Murtagh

14. MOTHER'S MAIDEN NAME: Alice Joder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) – (If yes, give war or dates of service) –

16. SOCIAL SECURITY NO.:

17. INFORMANT / Address: Husband Lt Col Harry J White (Item d)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Congestion and edema
522X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I ~~attended~~ examined the deceased ~~from~~ XXXX 31 May 19 61 to XXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Pronounced dead 10:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sherman S Robinson M.D.
ADDRESS (Street, city or town, state): USA Hosp Ft Geo G. Meade, Md
DATE SIGNED: 31 May 61

PHYSICIAN'S NAME (Type): SHERMAN S. ROBINSON, CAPT., M.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5 June 1961

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Rinaldi Funeral Home Inc
ADDRESS: 816 H St NE. DC

24a. REC'D BY REGISTRAR DATE: JUN 5 '61

24b. REGISTRAR'S SIGNATURE: [illegible]

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5167 5157

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Paradise Hill Farm

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
d. STREET ADDRESS: Paradise Hill Farm
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First [redacted] Middle A. Last WRIGHT
4. DATE OF DEATH: Month May Day 17 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 31, 1904
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Executive
10b. KIND OF BUSINESS OR INDUSTRY: Farm Implement
11. BIRTHPLACE (State or foreign country): Louisiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Willis M. Wright
14. MOTHER'S MAIDEN NAME: Sarah Co Hirell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Martha E. Wright Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): HEPATIC FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 WKS
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): METASTATIC ADENOCARCINOMA — MORE THAN 3 MOS
DUE TO (c): CARCINOMA OF HEAD OF PANCREAS — UNDETERMINED

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-3 1961, to 5-14 1961, that (I) (we) last saw the deceased alive on 5-4 1961, and that death occurred at 1:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Barber C. Palmer Jr. M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 5-15-61
22c. PHYSICIAN'S NAME (Type): Barber C. Palmer, Jr., M.D.
22d. ADDRESS: 77 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 5-15-61
23c. NAME OF CEMETERY OR CREMATORY: A. Lincoln
23d. LOCATION (City, town, or county) (State): Bladensburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons
ADDRESS: Annapolis, Md.
25a. RECD BY REGISTRAR DATE: MAY 19 61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59